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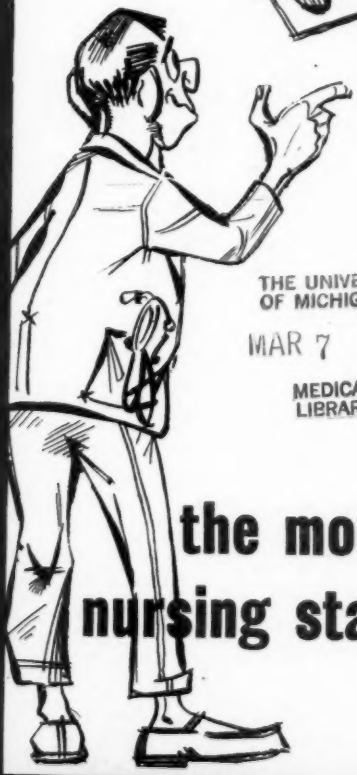

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p. 134

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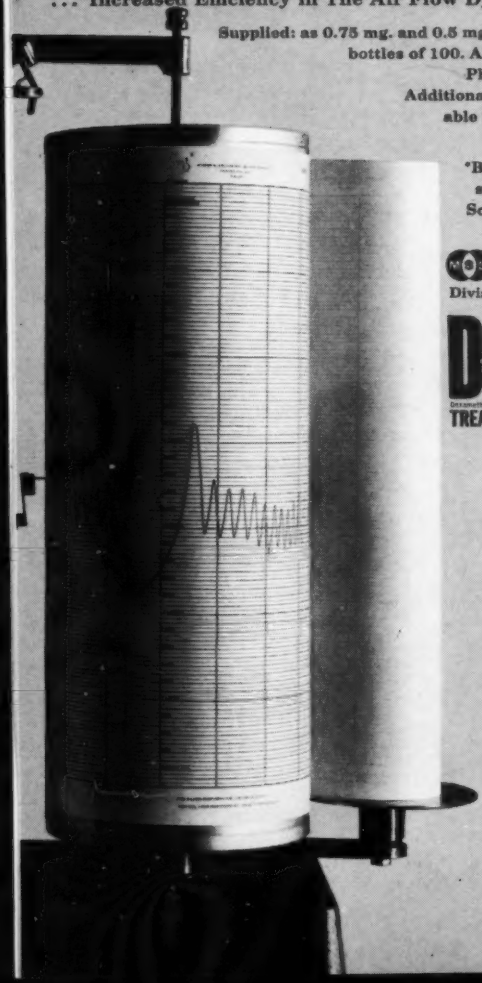

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***Bickerman, H. A., et al.: Physiologic and steroid therapy in respiratory disease, Scientific Exhibit, A. M. A. Convention, Atlantic City, N. J., June 8-12, 1959.**

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January 1961, Vol. 7, No. 1

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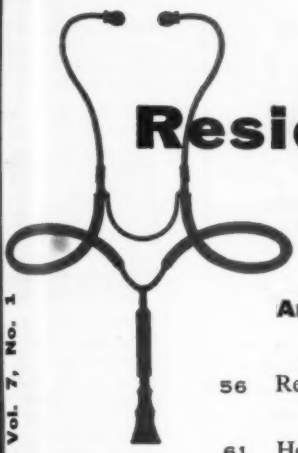

Resident Physician

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Female patient, age 55, complaining of nausea and epigastric discomfort after meals.

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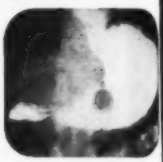
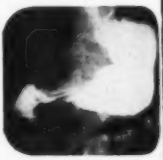


1 hour after barium administration: Retention of barium due to spasticity of the gastric outlet, and incomplete visualization of the pylorus, duodenum and duodenal sweep. (Some barium has entered the small bowel.)



20 minutes after administration of "Murel" 2 cc. I.V.: Barium entering duodenum and duodenal sweep as spasticity is relieved.

10 minutes later: Good filling of the gastric outlet as well as of the duodenal sweep.

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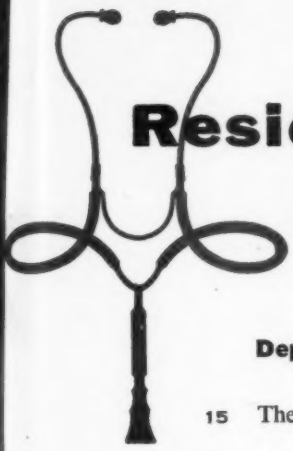

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Resident Physician

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1. Schulz, Jeanette and Smith, N. J.: A.M.A. J. Dis.Child. 95:109(1958)
2. Josephs, H. W.: Medicine 32: 125 (1953)
3. Recommended Dietary Allowances, NAS-NRC Publication 589 (1958)

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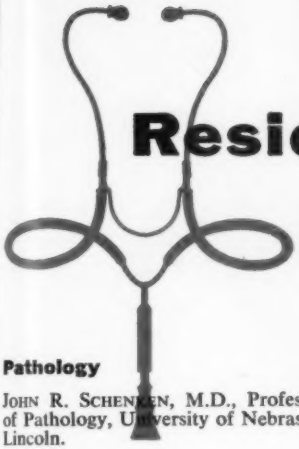

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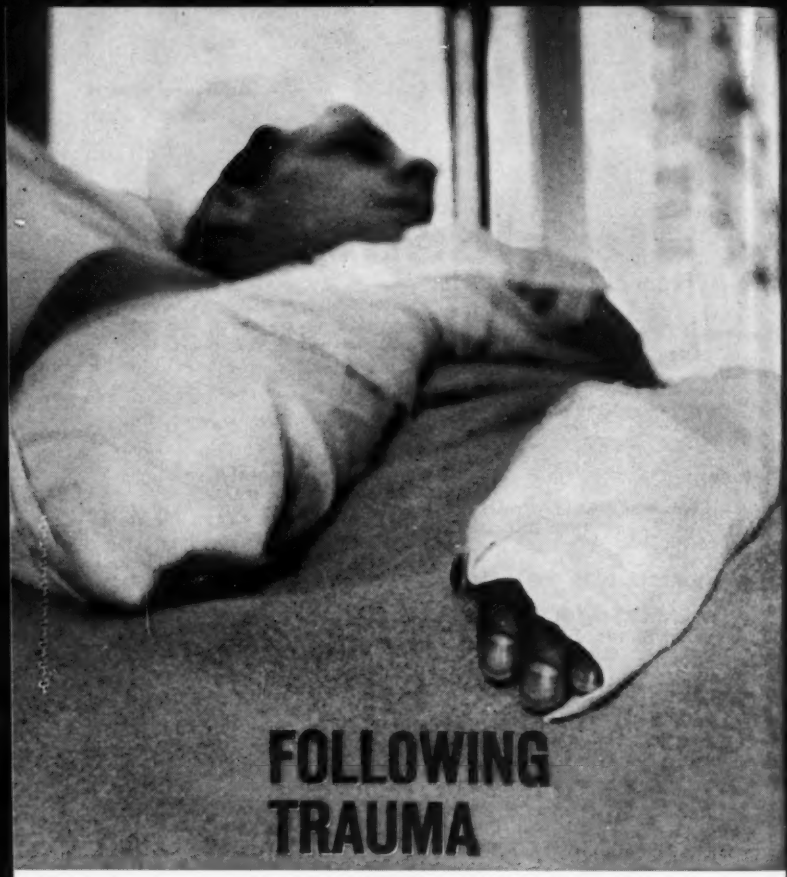

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1. Richardson, M. E.: J. Am. Osteop. A. 57:562 (May) 1958. 2. Mason, M. L.: Northwest Med. 57:1439 (Nov.) 1958. 3. Coleman, S. S.: Am. J. Surg. 97:43 (Jan.) 1959.

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Therapeutic Reference

The following index contains all the products advertised in this issue. Each product has been listed under the heading describing its major function. By referring to the pages listed, the reader can obtain more complete information. All products are registered trademarks, except those with an asterisk (*).

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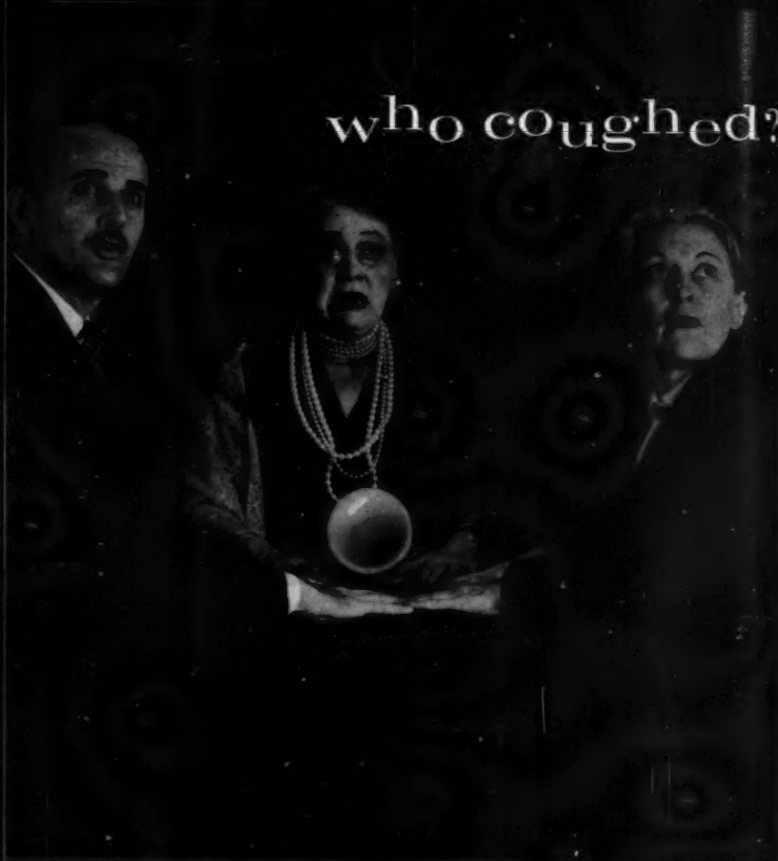

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cough sedative · antihistamine
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ENDO LABORATORIES
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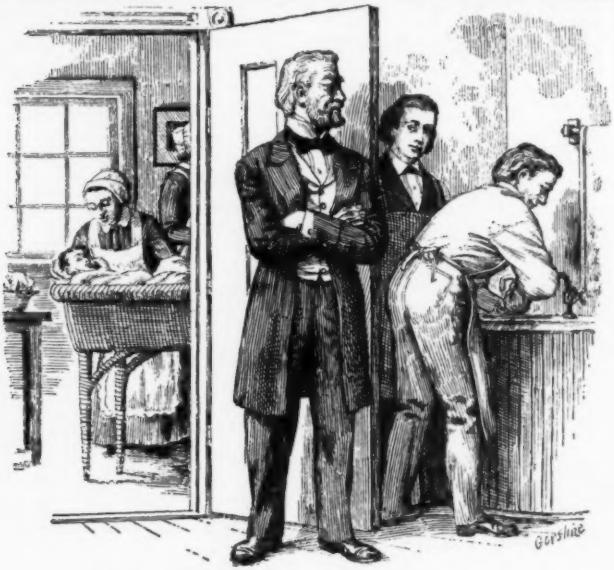

The "Clean Hands" Tyrant

In 1846, puerperal fever was considered an unfortunate consequence of childbirth. When Ignaz Semmelweis assumed his duties as assistant to the Chief of the First Obstetrical Clinic in Vienna, he noted that the Second Clinic, operated by midwives, lost far fewer patients. Seeking an explanation, Semmelweis and his students dissected the fatal fever cases, then returned to the wards to examine more women. The result of his zeal—an increased death toll! During one autopsy, Semmelweis' friend, Dr. Kolletschka, was nicked by a student's scalpel—and died exhibiting all the indications of puerperal fever.

Now at last, with this experience, Semmelweis perceived the danger of transferring contaminants and posted this notice at the door of his clinic: "As of today, May 15, 1847, every doctor and student who comes from the dissecting room is required, before entering the maternity wards, to wash his hands thoroughly in a basin of chlorine water. . . ." Semmelweis himself stood guard over the clinic and soon became a hated tyrant. But when the rapid decline in fatalities drew the attention of the Vienna Medical Society, his superior, Prof. Klein, fearing such a triumph for his young assistant, denounced Semmelweis as a traitorous revolutionary. Semmelweis, barred from the hospital, died in despair and obscurity. During the same year, 1865, Joseph Lister began his crusade for antisepsis.

—JURGEN THORWALD: *The Century of the Surgeon*, New York, Pantheon Books Inc., 1957, pp. 227-243.

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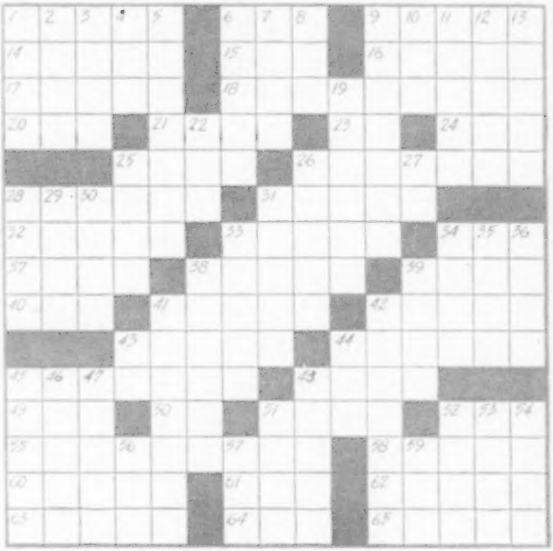
Resident Relaxer

(Solution on page 168)



ACROSS

1. Filterable agent in disease
2. Common Trichina Host
3. Litmus—
4. Gruel made of maize meal (Sp. Amer.)
5. —— Serrata
6. Oil formerly used to treat ulcers
7. The body's largest gland
8. Inflammation of the stomach
9. Compass direction (abbr.)
10. Resound
11. Right (abbr.)
12. Malt beverage
13. Represent in drawing
14. Rubeola
15. Prescribed amount of medicine
16. Swollen
17. Texas mission besieged in 1836
18. Large intestine
19. Male offspring
20. Monetary penalty
21. Faux pas (slang)
22. Half (prefix)
23. Pedal digit
24. L'Hotel Dieu is here
25. Pertaining to the eye
26. Pertaining to the ilium
27. Narcotic
28. Induct into office
29. Abdominal fat of a ruminant
30. A marshal of France
31. Symbol for neon
32. —— Price test for vitamin A in oils
33. Ulmus
34. Biotypes
35. Cessation of respiration
36. Hawaiian shrub used for making nets
37. Biblical high priest
38. Entire
39. Tether (obs. var.)
40. Sebaceous cyst
41. Put forth, as effort

DOWN

1. Farewell (L.)
2. Inflammation (suffix)
3. Wander
4. Diminutive suffix for nouns
5. Creeping eruption
6. Golf's "Ben"
7. Relating to the mouth
8. Nitrous oxide is one
9. Relate
10. Mohammed's son-in-law
11. Member of a corolla (Botani)
12. Zola's given name
13. What the temperature does in pneumonia
19. Parkinsonian has this
22. ——tic; Ipecac is one
25. Physically disabled
26. Stubborn ones
27. Sine Die (Abbr.)
28. Foolish
29. Medley
30. Mentally sound
31. Characterized by continuous tension
33. Skeleton of marine coelenterates
34. Bristle
35. Leave out
36. Fastidious
38. Hyde——; American botanist
39. Expectorate
41. Relating to the sole of the foot
42. Perform surgery
43. Pronoun
44. Possessive pronoun
45. Cast metal mass
46. Darnel (local U.S.)
47. An ecclesiastical council
48. The black buck of India
51. Suffix denoting a swelling
52. Grafting (Her.)
53. Shakespearean king
54. The seed of barley
56. Unit
57. Church bench
59. An eruptive disease

in emergencies

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in the patient in 30 seconds · in the plasma in 5 minutes

1. No dilution 2. No mixing 3. No waiting . . . in stable solution ready-to-inject with small-bore needle.

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Letters to the Editor

OB Office

With reference to your article in the November issue of RESIDENT PHYSICIAN on "Equipping the Ob-Gyn Office:"

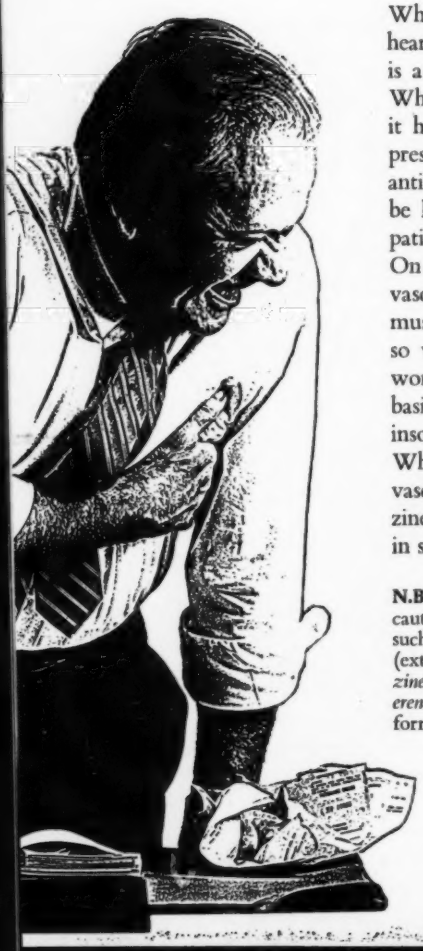
I would suggest to those interested in setting up their offices that they not make the mistakes that some of their colleagues have.

A fertility expert in Oakland, California has prints mounted on the ceiling over the examining table. The comments from the patients is that it makes them more nervous rather than lowering any tension. A general Ob-Gyn man in Connecticut has a large, floor-to-ceiling mirror in

—Continued on page 36

IN THE HEART PATIENT—COMPAZINE®
brand of prochlorperazine

TO LESSEN EMOTIONAL STRESS



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On 'Compazine', patients with cardiovascular disease can relax; those who must accept restricted activity can do so with equanimity. And the "heart worrier," whose symptoms have no basis in fact, often loses his palpitations, insomnia and vague pains.

Whenever anxiety aggravates cardiovascular conditions, consider 'Compazine', the tranquilizer-antiemetic used in several million patients.

N.B.: For complete information on dosage, cautions, contraindications and side effects such as occasional neuromuscular reactions (extrapyramidal symptoms) see: *Compazine® Reference Manual, Physicians' Desk Reference*, or your SK&F representative. Full information is also on file with your pharmacist.

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—*Continued from page 33*

the waiting room that simply increases the agony a pregnant woman feels at the thought of the distortion of her body.

With special reference to the quotation about having no chair in the office so the husband might not ask questions, I feel that as a psychiatrist, to have him understand and be in accord with treatment in general might be helpful to the practitioner rather than a hindrance.

HAROLD BOVERMAN, M.D.
BRANFORD, CONNECTICUT

PD Fellowships

I will greatly appreciate if I could obtain the information available about scholarships or Fellowships for graduate training and research in Pulmonary Diseases.

I am completing my second year residency in the West Tennessee Tuberculosis Hospital.

LUIS M. RODRIGUEZ, M.D.
MEMPHIS, TENNESSEE

• *In the October 8* Journal of the American Medical Association, *there is a listing of approved residencies, etc., in pulmonary disease. Select the hospital which appeals to you and write to: Chief of Service, Pulmonary Disease, with a request for information concerning fellowships.*

Citizenship and Draft

I am a foreign medical graduate planning to emigrate to the United States. Please let me know if I shall be eligible to be drafted under the Doctor's Draft Law, since I shall be taking my first papers and I have never served in the U.S. Armed Forces before.

I shall greatly appreciate being put on the mailing list to receive copies of the RESIDENT PHYSICIAN. I think a regular perusal of the RESIDENT PHYSICIAN will help me greatly to prepare for the ECFMG examination which I plan to take this year, in April. At present I am working as a resident in psychiatry.

How long does it take to acquire American citizenship if one joins the U.S. Armed Forces?

NAME WITHHELD AT REQUEST OF WRITER

• *Suggest you address your first inquiry to Colonel Paul Akst, Director, New York City Headquarters, Selective Service System, 205 East 42nd Street, New York 17, New York. State your age. Your second question should be sent to: U.S. Department of Justice, Immigration and Naturalization Service, 70 Columbus Avenue, New York City, New York.*

—*Continued on page 44*

It's obvious why the teenager is known for his appetite. His long bones are growing. He's building weight. His metabolic rate is up. He's undergoing the adolescent changes that make an adult. He *has* to eat to keep up with his accelerated development.

Unhappily, the teenager's *nutrition* isn't always as impressive as his appetite. Recent studies[1-6] show potentially serious deficiencies in the diets of many of our young people.

Fortunately, outright clinical malnutrition is rarely seen in U.S. teenagers. Yet even a suboptimal intake can become of real concern during illness or stress. This is particularly true of the teenage girl, whose diet is so frequently less than ideal—and upon whom an early marriage and pregnancy may be severely (and even dangerously) taxing. It has been suggested that the incidence of eclampsia, stillbirths and malformation in young mothers is greater in the presence of a poor dietary history.

To help the physician improve adolescent diet, Abbott now makes available a vitamin-mineral supplement—formulated especially for growing teenagers.

Called Dayteens, it is well fortified with iron and calcium—both important factors in adolescence, and both frequently deficient in the teenage diet. Another "essential" nutrient, ascorbic acid, is provided in 1½ times the Minimum Daily Requirement. Indeed, MDR's of all the essential vitamins are more than met. Trace minerals are included for the role they play in normal body metabolism.

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DAYTEENS[TRADEMARK] to supplement teenagers' diet

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			Boys 16-19	Girls 16-19
Vitamin A (5000 units)	1.5 mg.	1.2 mg. (4000 units)	1.5 mg. (5000 units)	1.5 mg. (5000 units)
Vitamin D (1000 units)	25 mcg.	10 mcg. (400 units)	10 mcg. (400 units)	10 mcg. (400 units)
Thiamine Mononitrate (B_1)	2 mg.	1 mg.	1.8 mg.	1.2 mg.
Riboflavin (B_2)	2 mg.	1.2 mg.	2.5 mg.	1.9 mg.
Nicotinamide	20 mg.	10 mg.	25 mg.	16 mg.
Pyridoxine HCl	0.5 mg.			
Vitamin B_{12} (cobalamin conc.)	2 mcg.			
Calcium Pantothenate	5 mg.			
Ascorbic Acid (C)	50 mg.	30 mg.	100 mg.	80 mg.
Iron	10 mg.	10 mg.	15 mg.	15 mg.
Copper	0.15 mg.			
Iodine	0.1 mg.			
Manganese	0.05 mg.			
Magnesium	0.15 mg.			
Calcium	250 mg.	750 mg.	1400 mg.	1300 mg.
Phosphorus	193 mg.			

TM—DAYTEENS, ABBOTT'S VITAMIN-MINERAL SUPPLEMENT FOR GROWING TEENAGERS

1. Everson, G. J. Bases for Concern about Teenagers' Diets. Journal of the American Dietetic Association 36:17-21 1960. 2. Van Syckle, C., Calcium in Urban Family Food Supplies. Journal of the American Dietetic Associatio 35:1283-1286, 1959. 3. Nutritional Status USA. Bulletin 769, California Agricultural Experiment Station, 1959 4. Stearns, G. Nutritional State of the Mother Prior to Conception. J.A.M.A. 168:1655-1659, 1958. 5. Hard, M. and Esselbaugh, N. Nutritional Status of Selected Adolescent Children. American Journal of Clinical Nutrition 4:261 268, 1956. 6. Eppright, E. S., and Roderuck, C. Diet and Nutritional Status of Iowa School Children. American Jour nal of Public Health 464-471, April, 1955.

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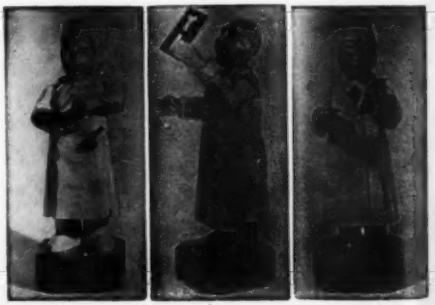
M5 M10 M11



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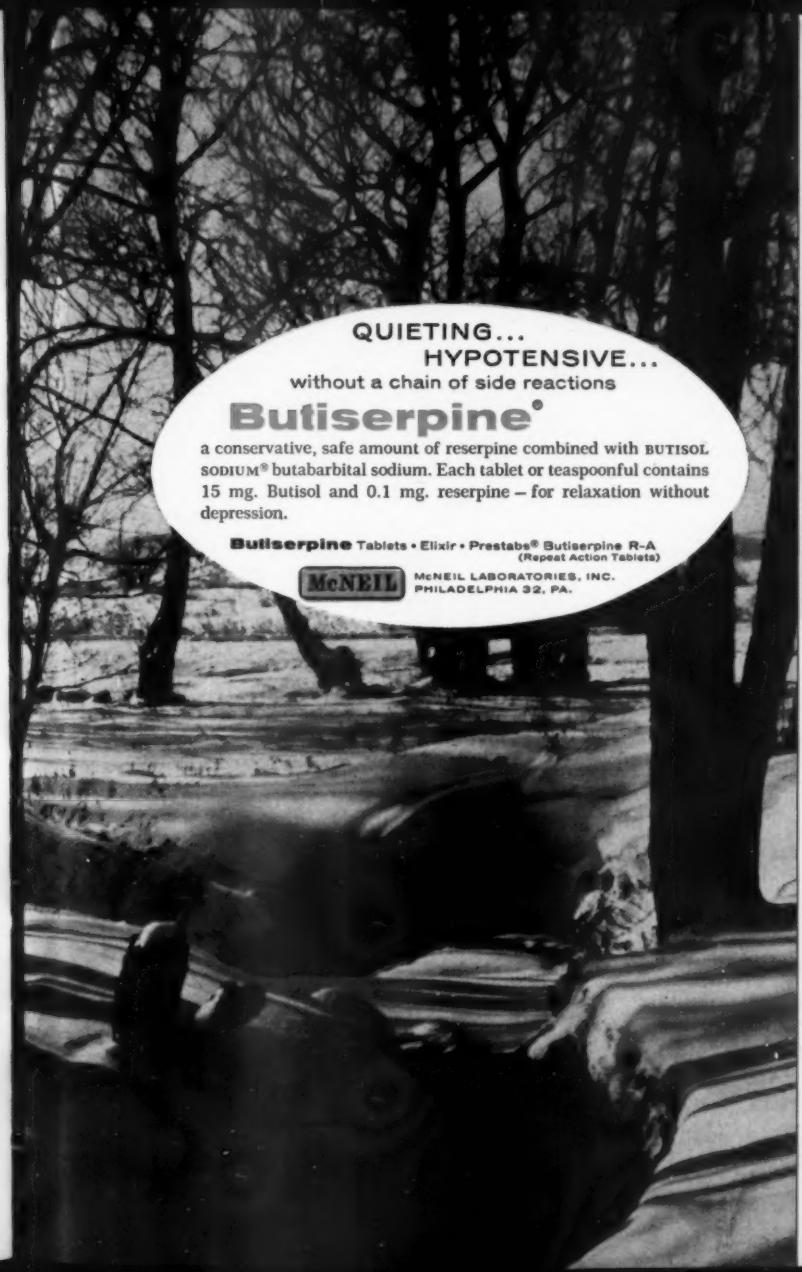
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—*Continued from page 36*

RP overseas?

Having finished my residency in this country I am preparing myself to return to my country, Brazil.

During my time spent in this country, RESIDENT PHYSICIAN was a helpful magazine in my medical training and I sincerely would like to keep receiving it in Brazil.

As I am leaving for Brazil within the next three weeks, I would appreciate it if you would let me know as soon as possible.

CID MARCOS
SILVA CYPRESTE, M.D.
ST. FRANCIS HOSPITAL
BRONX, NEW YORK

• *Sorry. Except for subscribers, our circulation policy does not permit sending copies to physicians overseas.*

Technician's Error?

I had the pleasure of reading your article "How the Law Views Blood Transfusions" in the September 1960 issue of RESIDENT PHYSICIAN. In the first paragraph, under the heading "Switched Labels," you stated the technician correctly typed and crossmatched the blood for two patients who were to undergo surgery.

In the next paragraph, you stated the anesthetist, without reading the labels, started the transfusion using the bottle meant for the second patient. It appears that the anesthetist was at fault for not reading the name on the bottle. You did not state the technician switched the labels during the labeling of the blood after the crossmatch. Technically, someone else could have switched the labels.

In our hospital, the labels with the patient's name, hospital room number and the doctor's name are pasted to the bottle of blood to avoid such a thing. My reason for comment is that the article is not too clear and you stated the anesthetist started the transfusion without reading the labels, yet the technician gets the blame. Too often, the technologist is blamed for other mistakes.

A. BRADFORD WELLS
ST. LOUIS STATE HOSPITAL
ST. LOUIS, MISSOURI

• *The subhead "switched labels" refers only to a part of the section which follows. The second paragraph following the subhead deals with one legal case in which the anesthetist was at fault. The next paragraph, however, deals with an entirely different case in which the technician mislabeled the blood. The two cases are in no way related. Both involve acts*

—*Concluded on page 50*

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"sinus" or frontal headache and congestion—whether from true sinusitis or rhinitis—yield promptly to Sinutab. In therapy or prophylaxis Sinutab rapidly and effectively aborts the pain, decongests the mucosa and relaxes the patient. Verify the value of Sinutab for yourself: you *and* your patients will be pleased.

MS11

for sinus and frontal headache

Sinutab®

WARNER CHILCOTT

—*Concluded from page 44*

of negligence. As you will note under "references" at the end of the article, there is a separate reference for each.

Contest Comment

I think your idea of trying to stimulate some better reading habits on the part of our house officers by means of the contest that you have outlined is very fine. I would have liked it even better if you had not limited the reading to medical journals or scientific material. I think perhaps even more than this we need to stimulate their reading of good literature, the classics, history and philosophy. . . .

C. J. WATSON, M.D.
UNIVERSITY OF MINNESOTA
MINNEAPOLIS, MINN.

. . . Our librarian has noted no significant trend. Our library is an extremely busy one with our active teaching program and approximately 130 residents, so that I think it would be rather difficult for any competition—no matter how attractive — to increase the usage of our Medical Library.

STANLEY CROSBIE, M.D.
VETERANS ADMINISTRATION HOSPITAL
MINNEAPOLIS, MINNESOTA

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Perrin H. Long, M.D.

Editor's Page

Veterans Administration Clinical Investigator

Dr. Wells' paper on The Veterans Administration Clinical Investigator provides some very interesting data and stimulates the raising of certain questions. To begin with we note with interest that this program which was conceived with the help of some of the best brains in American medicine and which, in a certain sense, is uniquely set up and well founded, has attracted but slightly over one hundred applications in roughly four years. This in itself is surprising and makes one wonder, "What in the world do people want today? The moon?" Here is a top flight program which is drawing an average of twenty-five applications a year!

Another matter of interest: of those accepted into the program (fifty-four clinical investigators) all but eight have been trained in internal medicine. Six young men trained in surgery, one in dermatology and one in psychiatry comprise the remainder of the individuals in the program. It would appear to be a disproportionately small number of individuals in the fields other than medicine. For example, let's consider surgery. Currently, there are 4,590 fully approved surgical residency spaces available in this country. The fact that but

six surgeons are in the program may be considered as an indication that the aims and drives of young surgeons currently are such that these young men are not drawn into research but rather into practice as promptly as possible. The fact that but one dermatologist is in the program is also shocking because it would be your Editor's opinion, based on many years of experience that one of the fields which properly trained investigators could till with great profit is that of dermatology, or as some like to call it, cutaneous medicine. The opportunities certainly are great.

Most surprising of all, however, is the fact that there is but one psychiatrist in the program! This is extraordinary when one considers that psychiatric patients constitute a major problem in the hospitals of the Veterans Administration. Furthermore, there are 3,450 fully approved residency spaces for psychiatric training in our country and of these, over 400 are in the hospitals of the Veterans Administration.

Now at the risk of being attacked from all sides, your Editor is going to speculate a bit on the subject of research in psychiatry. During the last forty years many, many millions of dollars have been spent in so-called psychiatric research, but in comparison with certain other areas of medicine the returns by and large have not been spectacular. None of the Nobel laureates with the exception of Von Jauregg have been psychiatrists. But immediately one will raise the question: "But what about the development of psychoanalysis as a research tool?" Well, the fruits of analysis have often been philosophical rather than scientific.

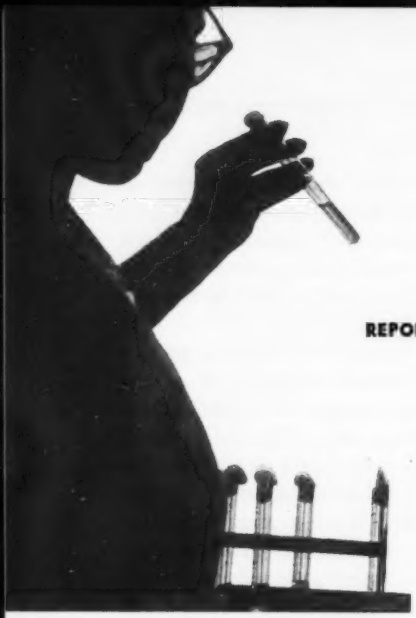
No one will deny that the contribution of Freud, Jung, Adler and a few others in the field of analysis have added new facts to our knowledge of the mind and its workings and that a few others through biochemical, neurophysiologic, psycho-biologic and therapeutic inquiries have done work which has resulted in the revision of accepted conclusions in light of new facts which have been unearthed. But most of

the so-called research has had to do with minor variations of the same theme in very minor keys. In other words, as one looks into the various psychiatric journals, one finds much which is called research but from our editorial point of view is taxonomic or nosological, and subjective and uncontrolled.

The problem of the objective approach is major in psychiatric research as is also the statistical evaluation of results which are believed to have been obtained. A number of individuals who have given thought to the problem of research in psychiatry have wondered if one phase of psychiatric training; i. e., the training analysis is in reality a stultifying experience as far as the development of latent research potentials in young psychiatrists are concerned. Certainly, over the years, your Editor has seen some of his younger colleagues really disturbed to a point where their academic work suffered, while undergoing their training analysis. Obviously, such experiences exert dampening effects on the inquiring mind.

In conclusion, we can urge that residents who have a research bent investigate carefully the potential benefits of the Clinical Investigator Program of the Veterans Administration. It offers great opportunity, adequate research funds and more than a living wage to young investigators. It is especially to be hoped that those who are interested in psychiatric research will carefully consider this program. It should provide them with an especially satisfactory environment in which to carry out studious inquiries.

Perrin H. Long.



REPORT OF PROGRESS

VA Clin

In 1956, the Department of Medicine and Surgery of the Veterans Administration launched one of the most exciting ventures in its long history of medical service to American veterans. A new type of hospital appointment was created. The new appointment, called the Clinical Investigatorship, made its bid for young physicians who had been fully trained in one of the clinical specialties and who also had demonstrated an aptitude and promise in research.

The prime objective of the program is to encourage talented young people to supplement their knowledge and skills in clinical medicine with an equal competence in the sciences and technology from which modern medical practice is developed.

Ideally, there should be no dichotomy of medical science and medical practice. Methods of good practice are drawn from the basic sciences; the alert physician returns to the laboratory for solution to the unanswered questions of practice. The Clinical Investigator, thoroughly grounded both in the care of patients and some phase of basic research, should be an effective catalyst to this creative exchange.

Through its Deans Committee plan, begun ten years earlier, the Veterans Administration demonstrated that the quality of medical care in VA hospitals and clinics could be enormously improved by a vigorous program of education. It was inevitable that

Benjamin B. Wells, M.D.*

A Clinical Investigator

the type of physician recruited into this teaching and learning atmosphere would also be active in the field of clinical research. It was thus that the Veterans Administration research program was initiated and is carried on today. The Clinical Investigator program was an extension but not a change in this concept.

The new type appointee is first of all a physician and an effective clinician; his problems are those that arise in the treatment of patients. But the Clinical Investigator, paid by research funds of the agency, is permitted to make a major objective of his laboratory studies. He is provided some technical assistance and a modest budget for supplies and equipment.

Along with his research projects, the Clinical Investigator is encouraged to learn new technologies either at his own hospital station or by assignment to other institutions, in or out of the Government. Each Clinical Investigator is assigned a preceptor to assist in the planning of his work and to assure the fulfillment of his research and training objectives. Preceptors are men from within or without the Veterans Administration who have established reputations in the scientific and clinical fields.

The duration of the Clinical Investigatorship was set at three years. A program of this length is calculated to discourage those who have a casual interest in research or who would only like to dabble a bit in the laboratory while awaiting some further career development. On the other hand, three years seems long

* Department of Medicine and Surgery, Veterans Administration, Washington, D. C.

enough to accomplish a thorough indoctrination in principles and scientific methods as they apply to the problems of clinical medicine. No extensions of the assignment have been permitted. The program was not intended as a career or to produce a continuing body of full-time researchers. The purpose was, and is, training, orientation, and infusion of scientific discipline for a physician whose primary commitment is to the practice of medicine. A program of this duration and intensity is almost certain to produce men and women who will never be content to accept the average standards of professional performance, who will always subject themselves and their environments to intellectual criticism, and who will continue to probe the vast unsolved areas of medical science.

Appointments

How has the program fared in the years since 1956? The first group of Clinical Investigators was appointed to go on duty in January of 1957. To date, a total of 65 appointments have been made from 119 applications presented to the national Selection Committee. Most Clinical Investigators have come from the field of internal medicine, 54 of those appointed thus far. There have been six surgeons, three pathologists, one dermatologist, and one psychiatrist. There have been three women physicians appointed. All specialties, except those that deal primarily with women and children, are equally acceptable. Obviously, there is a need for more applicants from surgery and psychiatry, particularly the latter, since psychiatry carries so large a proportion of

Yes . . . .

Mediquiz is Back!

Starts on page 159

the patient load in the Veterans Administration.

Nominations are initiated at the local level where candidates are carefully screened by the Deans Committee from the affiliated medical school and by the hospital's own research committee. Only a select few are recommended to the hospital manager and finally processed through the central office in Washington. The national Selection Committee, a group of outstanding medical scientists from outside the Veterans Administration, conducts a careful study of each candidate and makes the final choice.

Board qualified

The candidate for appointment as a Clinical Investigator must have completed the formal residency training required for certification by the American Board in his particular specialty. It is not expected that he should have attained the status of a fully qualified independent investigator at the time of application, but he should have demonstrated during the course of his residency training a definite interest and aptitude in research. Since most residency programs now incorporate some opportunity for research participation, it is generally possible to make a reasonable prediction of interest if not of capability along these lines.

The Clinical Investigator is appointed in very much the same manner as other full-time members of the hospital staff. He is appointed at Department of Medicine and Surgery Intermediate Grade with a beginning annual salary of $10,635. He is eligible for the standard, periodic in-grade raises. If the candidate is certified by an American Specialty Board, he is entitled to an additional 15 percent in salary.

Other supports of the Clinical Investigator will vary, depending on the nature of his research projects. On the average, he will be provided one technician and from $2,000 to $10,000 in supplies and equipment each year. His laboratory, office, and much of his basic equipment are furnished from the general research services of the hospital to which he is appointed.

Just this year, the program had its first "graduates." It is too early to generalize on statistics, but this is what has taken place: Eighteen Clinical Investigators have taken full-time staff positions in VA hospitals. These are key positions of responsibility in the system. Three have joined the faculties of medical schools in full-time teaching and research

assignments. Ten have entered the private practice of their specialty. At the present time, there are 32 Clinical Investigators on duty in Veterans Administration hospitals. For 1961, there are 25 applications pending action by the Selection Committee.

Important role

What are the prospects for the future? The Veterans Administration feels that its Clinical Investigators are destined to play an important role in the maintenance and continuing improvement of practice in its own hospitals and clinics. Many of the Investigators will, no doubt, serve the urgent needs of our medical schools in teaching and research. The program is a small one, geared to the basic mission and facilities of the Veterans Administration hospital system. Current plans would increase the total number of Clinical Investigators during the next ten years to no more than three times the present number on duty.

To many, the selection process appears too rigorous. The Veterans Administration sees this as a proper protection, not so much to itself, but to the young physician who has much to lose if he commits himself injudiciously to a program of this duration and intent. There is not likely to be a real surplus of eligible candidates for this appointment. It takes a lot of resolution and mature judgment to undertake three years of research training on top of a complete residency program. The potential rewards are great, but it is not a decision to be made lightly.

OVERSEAS DEPENDENTS: STATUS UNCERTAIN

In mid-November, President Eisenhower issued a directive calling for the return to the United States by July 1, 1962, of about fifty percent of the dependents of overseas military personnel. The bulk of these returnees will be dependents of Army personnel. What effect this order will eventually have on dependents accompanying Army personnel overseas cannot be foreseen at this time. Much of what happens in the next eighteen months will depend on the policy of President Kennedy's administration relative to this problem. RESIDENT PHYSICIAN *will do its best to keep its readers accurately informed on this matter.*

How to Equip the Urologist's Office

What equipment is needed by the urologist who is completing his residency and preparing to open an office? RESIDENT PHYSICIAN *recently put this question before a number of practicing urologists. All agreed on one point: if you plan carefully, compare features and costs of similar items, you can save a considerable amount of money without sacrifice of essential equipment.*

In furnishing offices for the practice of urology, two points should be considered at the outset.

First, the urology practice deals for the most part with adult patients, the majority being elderly.

The second factor concerns a frequent complaint of the urology patient: incontinence. The latter, of course, indicates that the urologist's lavatory should be accessible from the waiting room.

Waiting room

Since the elderly adult is apt to be considerably less agile than, say persons in their thirties, care should be taken that the waiting room is as accident-proof as possible. For example, though surveys of specialists other than urologist's were in favor of easy-to-maintain tile flooring in the waiting room, urologists were not in agreement.

Office equipment you'll need in private practice

This is the sixth in a series of exclusive articles on equipping your office for the private practice of your specialty. It is based solely on a survey conducted by your journal among practicing specialists. Prices quoted are approximate and represent new equipment unless stated to the contrary. When a wide range of price and quality is available for a specific item, this fact is indicated.

Floor covering

The majority of urologists questioned in the survey indicated that tile floors were more slippery; consequently the less agile patient was more likely to lose his footing. Most reported that they had covered their waiting room floors with some form of carpeting.

The cost of broadloom or mixed wool and viscose carpeting runs between $8 to $15 a square yard, including underpad. A waiting room measuring 12 x 15 feet would require between $150 to $250 for carpeting, depending on the quality of the carpet and also whether wall to wall carpeting was used. (Most urologists responding did not cover their entire floor dimension with carpet.)

Furniture

The basic item of furniture in the waiting room is the chair. Urologists generally allowed for the fact that their patients would often be accompanied by a friend or relative at each visit. Thus, a couch and three other chairs would accommodate perhaps three or four patients. (This, incidentally, was the average accommodation reported by practicing urologists; most were careful in scheduling appointments.)

The type of chair used in the waiting room depends upon various factors. Plastic or leather-covered, and upholstered or foam rubber are equally comfortable. However, as with other specialties, many urologists expressed a preference for the plastic-type chair because of its durability and the ease with which it can be kept clean; a cloth dampened in water is all that is required to care for this type of furniture. There is little to choose between types as far as cost is concerned. Any good chair will cost from $30 up

to $80. Average price per chair reported by those surveyed was $50.

Necessary items

Other pieces of waiting room furniture required by urologists included lamps, tables for magazines, wall decorations, ashtrays and, if desired, some type of indoor plants. Here again, the urologist will be guided by the ages of the majority of his patients.

Table lamps were preferred, each equipped with no less than a 100 watt bulb and carefully shaded to throw light down on the lap of the patient who wishes to read.

Ashtrays should be plentiful. To prevent the possibility of damage to furnishings caused by spilled ashes or a burning cigarette, buy only the big, bowl-type ash trays; they can be attractive and functional. More than half of the urologists reporting had at least one movable ashtray and stand.

Tables should be sturdy and provide a large expanse of surface to accommodate a sufficient number of magazines and ashtrays. Cost need not exceed $40 for each table—unless you wish to use expensive period furniture. Lamp prices vary from just under $30 to nearly $60. The lower range offers an attractive and durable selection.

Consultation room

The consultation room can be kept simple and uncluttered by limiting the amount of furniture included. Carpeting on the floor adds dignity and together with drapes on the windows, contributes to the sound-proofing of the room.

The major pieces of furniture are those for the urologist himself; a desk and chair. Since a great deal of time will be spent here alone by the urologist, the chair should be one which he has tried and found to his liking in both comfort and appearance. Desk chairs which tilt and rotate can cost from $70 to as much as $200. The main thing, however, is that it fit the urologist comfortably.

Desks vary in price from $75 to $400. The desk should fit the room, not fill it. All consultation room furniture should be in the same style. Other than the physician's own chair, one chair will be provided for the patient (cost $40-$75) and another for a friend or relative of the patient. These, too, should be comfortable so that a lengthy history-taking session doesn't unduly tire the patient.

According to responding urologists, bookcases have a double advantage in the consultation room. They are decorative in themselves, and they provide a storage space for much of the clutter that often finds its way to the top of the specialist's desk. (This last point is of more importance than you may suspect. A sloppy, unkempt desktop often gives the patient the impression that the physician is confused and disorganized—hardly a good impression for any physician to give to a present or future patient.)

Attractive bookcases are not cheap, whether bought ready-made or custom made. However, used bookcases of good quality can be purchased at a considerable saving. Built in bookcases offer an excellent way to utilize odd-sized wall areas, but here too, expense is a big factor—unless you happen to be fortunate enough to have a carpenter or cabinet-maker as a patient.

The majority of urologists surveyed had a viewbox in the consultation room. A large number of the urologist's patients are referred and bring x-rays with them on the first visit which must be read by the urologist. A new viewbox will cost from $25 to $150, depending upon construction and the number of frames.

Cystoscopy room

The average urologist has two examining rooms; one for cystoscopy and one for routine physicals. The major piece of equipment in the cysto room is the cystoscopy table. A simple table can be purchased or one which combines an x-ray unit for retrogrades and intravenous pyelograms.

The majority of urologists reporting (70%) stated they had purchased an x-ray unit immediately upon entering private practice.

One reported: "You can't consider yourself a urologist without an x-ray for IVPs and retros—you would be more nearly practicing internal medicine than urology."

The minority who stated they did not purchase an x-ray immediately gave "high cost" as a reason for deferring this piece of equipment.

A new cysto table without x-ray may cost as much as $1200. A used table in good condition will be from $200 to $500. The required x-ray unit (100 ma.) will cost from $1500 to $3000. Darkroom equipment and plumbing must also be added to this cost. Average cost of darkroom equipment with a five gallon tank ran under $250 for the surveyed

group of urologists, excluding plumbing.

In addition to the table, an irrigation stand will be needed. A complete unit including spotlight will cost from $100 to $150. It will cost less for a wall type unit without the stand. Two stools at about $20 each will complete the table unit grouping.

Though such things as decor, style and layout of an office are best decided by each physician (or his wife), the resident would be wise to visit an office equipment firm since many offer a free consulting and advisory service. Some will even furnish your entire office on the cuff—and at reasonable bank rates.

Cystoscope and cautery

Cystoscopes, of course, are required. The majority of urologists started in practice with two, each costing from $175 to $300.

Roughly a third of beginning urologists purchased an electric cautery. Prices paid averaged $450. The majority reported they did not have nor did they intend to purchase this piece of equipment. "Any required cauterization should be done in the hospital," according to one respondent.

Sounds, catheters

Varying sizes of sounds and catheters are required, of course. A complete set of ureteral catheters is needed. Average total outlay for this group was $150. Commonly found in the cysto room was a wall type viewbox in addition to the one located in the consultation room. Also, a medicine cabinet, average cost near $80, was reported by many practicing urologists.

Other equipment

Additional equipment listed by most urologists included those items needed for routine urinalysis, blood counts and sed rates. A centrifuge, if purchased new, will cost no more than $75. A new microscope will cost from $250 up; secondhand prices usually start at $150.

The average urologist preferred cold sterilization for catheters and sounds. But most indicated the need for a fourteen or sixteen inch sterilizer for instruments and syringes. Purchased new, such a sterilizer will cost in the neighborhood of $75.

Drugs and dye supplies will cost under $50. One point made by a number of respondents was that such items as adrenalin, cortisone and antihistamines

should be on hand for the treatment of allergic reactions occurring in the office.

Second room

Many urologists have a second room for basic examinations. This can be equipped simply and at small cost. A suitable table can be purchased for as little as $100 — or a standard examination table can be obtained at prices beginning at $250.

In this room can be located a scale. Cost will be between $50 and $75. In addition, a treatment stand and instrument cabinet can be installed as part of the examining room equipment. Illumination can be from a simple spotlight ($20) or a more elaborate overhead lamp (up to $150).

Extra lavatory

According to many urologists, an additional lavatory, one which is not accessible from the waiting room, should be available to patients in examining and cystoscopy rooms. Furnishing the lavatory with mirror, table, chair, disposal can, etc., should cost less than $75.

Printing

There are a number of incidental items which should be included in the office equipment budget. One of the most important of these, but often overlooked until the last minute, is "printing." This would include your announcements (to let the other doctors in your community know you're in business), personal cards, letterheads, billheads, case records, bookkeeping forms, etc.

The total expenditure you can expect to make for this type of necessary professional printing will be about $75. There are firms which make a specialty of supplying doctors' printing needs. Quite often it will save you time and money to order your forms,

stationery, and a bookkeeping system from these specialists. In most cases, you can make all such arrangements by mail.

Basic needs

The foregoing represents the basic needs of the beginning urologist, according to RESIDENT PHYSICIAN poll. The selection made in this discussion of essential equipment comprises an average estimation of that equipment which will be basically useful to the beginning practice. Prices in all cases are for new equipment and give only the approximate range for each category.

Many offices can be (and are) much more elaborately equipped. Also, special consideration was given to price. In modern day merchandising, credit terms can be made so attractive to the beginning practitioner that in many cases it may be wiser to purchase an income-producing item on credit, rather than to defer it.

Average costs

We asked each member of the survey group to give an approximate figure for the cost of outfitting his original office. The figure was to be complete, but excluding such items as typewriters, nurse's desk, nurse's chair, filing cabinet, etc., some of which you may be able to do without.

About half of the urologists equipped their offices with an expenditure of less than $5000. Nearly 30% reported initial equipment purchases of $5000 to $6000. The remainder of the group spent $6000 to $7000.

"If this ever happens again, insist on a house call!"

FOR INCOME TAX PURPOSES . . .

Are Your Meeting and Convention Expenses

Viewed by the tax collector, the practice of medicine is considered to be "conducting a trade or business" and permits the deduction of a doctor's business expenses from gross fees received.

An individual engaged in a trade or business is allowed, under Section 162 (a) of the Internal Revenue Code of 1954, to deduct "all ordinary, reasonable and necessary expenses" paid or incurred during the taxable year in carrying on such trade or business.

This same section also provides for the deduction of *traveling expenses* (including the entire amount spent for meals and lodging) while away from home *in the pursuit of one's trade or business.*

But what of the costs involved in attending meetings and conventions of medical societies? Are these deductible?

Back in 1952, H. B. McNary, a consulting engineer, was denied the right to deduct for the cost of attending professional meetings (11 TCM, CCH Dec. 19084).

Despite this adverse Tax Court Memo, there seems to have been a liberalization on the part of the Internal Revenue Service in connection with the deduction allowed for such expenses.

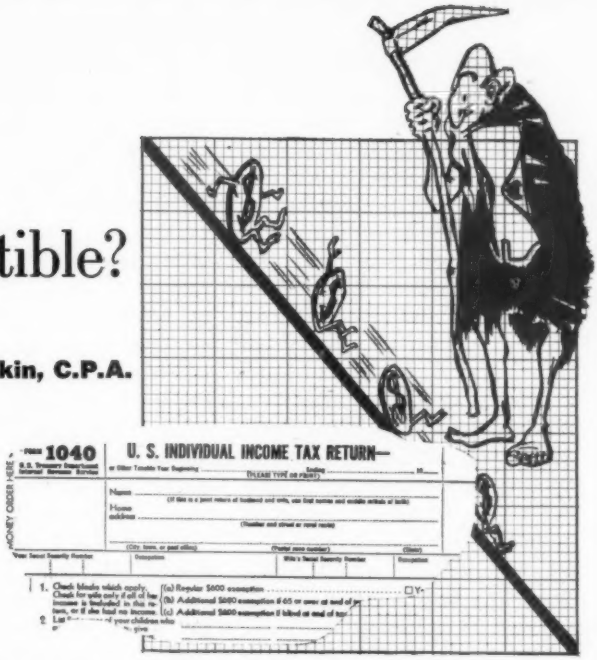
If certain qualifications are met, the costs of attending conventions or conferences are held to be deductible, including food and lodging while away from home, incidental travel expenses, and the actual cost of travel to the convention site.

Mere membership in a professional organization, however, does not entitle a taxpayer to deduct expenses of attending a convention of the organization, unless his attendance is in connection with his trade or business.

It is the opinion of this writer that because the cost of attending

se eductible?

Joseph Arkin, C.P.A.



a convention is a proper expense, it would follow that the costs of attending local meetings would fall into the same category.

The expenses in connection with a taxpayer's wife accompanying him on a convention trip are deemed to be personal in nature and are not deductible.

One exception to this rule is where it can be shown that the services of a secretary are essential and the wife actually fulfills the duties of a secretary and her presence is not purely for personal reasons.

Another exception is where it can be shown that the presence of the wife is absolutely necessary for a bona fide business reason. The burden of proof in these instances rests upon the taxpayer.

That portion of the expenses of sightseeing and visiting friends and relatives in the convention city or area are considered to be personal expenses and hence not deductible.

Where a medical society appoints a delegate to attend a regional, national or international conference or convention, the tax-

payer does not, merely because of that status, become entitled to deduct as business expenses the expenses incurred in connection with his attendance at such convention. In order to be deductible by him, the expenses must be incurred in carrying on the "taxpayer's own trade or business activities," as distinguished from those of another taxpayer or entity.

The delegate's allowance of deductions for convention expenses as business expenses will depend upon whether the relationship between the taxpayer's trade, or business, and his attendance at the convention is such that by his attendance he is benefiting or advancing the interests of his trade.

One method of determining whether such a relationship exists is to compare the individual's duties and responsibilities of his own position with the purpose of the meeting as shown by the program or agenda.

A discussion of a delegate's deduction of convention expenses is covered in detail in Revenue Ruling 59-316, I.R.B. 1959-39, page 7.

Where a doctor is an employee of a hospital, clinic or of another doctor, he can deduct certain expenses in connection with attending conventions.

If an employee's expenses meet the test of Section 162 (a) of the Code, as ordinary and necessary expense incurred in connection with the performance of his services as an employee and consists of traveling expenses, transportation expenses, or expenses for which he is reimbursed by his employer, such expenses are deductible under Section 62 (2) of the Code in computing adjusted gross income.

Thus, the taxpayer can deduct the expenses incurred and still be eligible to use the tax table or to take the standard deduction.

Where the expenses are not reimbursed by the employer, an employee is permitted to deduct the cost of attending conventions if directly connected with his employment*. In this case, the expenses of travel, meals and lodging are deductible on page 1 of Form 1040. Entertainment, gifts, and certain other expenses are deductible on page 2 under the heading, "Miscellaneous."

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* The right to this type of deduction has been established by a **secretary** in Callinan, 12 Tax Court Memo 170, CCH Dec. 19472; a **clergyman** in Shutter, 2 Board of Tax Appeals 23, CCH Dec. 510 (acq.), a **teacher** in Perkins, 11 Tax Court Memo 532, CCH Dec. 19006 (m), and employees generally in Ratterman 7 Tax Court Memo 476, CCH Dec. 16, 509 (M).

Eugene A. Osius, M.D.

Guest Editorial

Role of the Teaching Hospital in the Development of a Physician

In the continuing educational process which characterizes the life of a physician, the teaching hospital occupies an early and important role. That education is a lifelong process was fundamentally stated by Plato and reiterated by Sir William Osler in relation to medicine. Only the beginning of this process occurs during formal college training.

The teaching hospital, as well as other hospitals, has as its primary aim, patient care of the highest possible quality. However, having accepted an educational role as a part of its obligation, further responsibilities befall such a hospital. The opportunity for learning must be created to encourage initiative, curiosity, and an investigative approach to clinical medicine.

These opportunities for learning must first be realized by the establishment of an organized teaching program. The organization of the hospital staff into a type of faculty, whether it be full-time, part-time, or voluntary in character, is necessary. The essential factor, as in all medical teaching is the dedication, inspiration and local administration of this faculty. Along with the development of this program, periodic self-appraisal is essential to determine points of weakness which

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Harper Hospital

might be changed to fulfill the needs of training the house officer.

Robert I. McClaughry quotes Dietrich and Berson as having said, "The curriculum is the loom on which the cloth of medical education is woven."

In order to effect this educational function, the administration of the hospital must be cognizant of the aims of its staff and must provide an adequate budget for this purpose.

Some current thought has it that the internship may be unnecessary or outmoded. I believe, however, that it represents a vital period of transition between the didacticism of the medical school, and the clinical responsibilities of residency training and of clinical practice. The development of the clinical clerkship has been thought to fulfill, in part, the needs of an internship, but the advantages of a good internship are that assignments can be made for several weeks, and there are opportunities for patient care, continuous exposure to clinical instruction and a progressive responsibility. Consultations and seminars in individual specialties also answer the need for exposure to these fields. Guidance and proper facilities should be available for the intern with an interest in research. The success of any such program depends upon the presence of a stimulating staff, an organized teaching program, adequate facilities, and avid pupils as the soil upon which medical thought and ideas can be sown.

Many of the things to be learned in an internship must be taught by precept and example, both by the resident staff and the attending staff. Seminars, conferences, didactic lectures and clinics all perform necessary functions in the total picture but are probably secondary to teaching by precept and example and contact with patients.

Fortunately, remuneration is no longer a deterrent nor need it impair motivation.

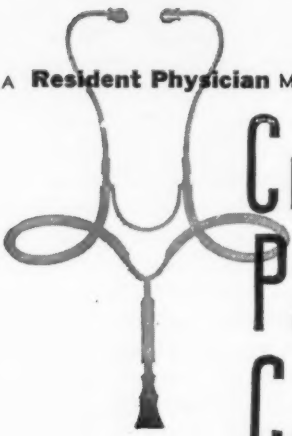
The university ideal in producing the medical graduate should be to form habits of scholarship, develop an inquiring mind, spark curiosity and these to precede advanced study. The sense of responsibility and appreciation of ethical duty to continue this education throughout the period of his professional life must be instilled in the young physician. The understanding, mutual criticism and supervision of his medical elders prevents the young physician from becoming stagnated and keeps his standards from slipping. It has long been recognized that the teaching hospital is probably the best hospital. Aside from our local and national obligation in the pattern of medical training, the world has come to look upon the United States with its well-equipped and research motivated hospitals for advanced training. The emphasis has thus shifted from the renowned centers of Vienna, Paris, Munich, and the noted teaching hospitals of London and Edinburgh, to the United States.

Raymond B. Allen, Chancellor of UCLA, in addressing the First Plenary Session of the Second World Conference on Medical Education, said, "Medicine, with its age-old concern for the sick, the poor as well as the rich, the weak as well as the strong, has been an influence for good, surpassed only by the moral precepts of religion."

What greater stimulus could the young physician receive to extend his personal knowledge and skills and to master the science and art of medicine in order that the impersonal effects of a highly technological age may be interpreted and applied to the healing art. Thus the opportunity to serve his community and nation and to extend the bond of international friendship and understanding that must exist between all peoples is offered to the physician.

Far from being a continuing burden, the necessity for incessant study in his maturation should dedicate the physician in his effort to embrace the wisdom of men, the knowledge of the sciences and the arts for serving his fellow man. This is the greatest privilege of all.

A **Resident Physician** MONTHLY FEATURE



Clinical Pathological Conference

Harper Hospital, Detroit

Internist

Richard J. Bing, M.D., professor and chairman, department of medicine, Wayne State University; attending physician and director of student teaching, department of internal medicine, Harper Hospital.

Pathologists

John R. McDonald, M.D., professor of surgical pathology, Wayne State University; director, department of pathology and research, Harper Hospital.

Andrew R. W. Climie, M.D., instructor in pathology, Wayne State University; pathologist, Harper Hospital.

First admission March 19, 1956: A 31-year-old Negro male was admitted to Harper Hospital with a recurrent right inguinal hernia which had been repaired twice previously and was again causing discomfort. Past history was completely negative. Family history revealed that both parents had died at age 59 of heart disease and high blood pressure, and that he had ten siblings all living and well.

Physical examination was completely normal. His blood pressure was 120/80. Laboratory results were also normal except for

a doubtful presumptive Kahn test. A right inguinal herniorrhaphy was performed successfully and the patient was discharged on March 27, 1956 after an uneventful postoperative course.

Second admission April 15, 1959: During the intervening three years, the patient had been well until one month prior to admission when he developed a mild sore throat with rhinorrhea. Weakness and progressive shortness of breath followed. Orthopnea, chest pain, ankle edema, and cardiac palpitations developed. The shortness of breath became much more severe in the two days prior to admission. He also reported some anorexia and regurgitation of food during the month before admission. Two episodes of hemoptysis had occurred, one month, and four days prior to admission.

Physical examination revealed a well developed and well nourished, adult Negro male. The blood pressure was 140/115, pulse 120, and respirations 20. His throat was mildly inflamed. The external jugular veins were distended but not pulsating. A few moist rales were heard with decreased breath sounds at the base of the left lung.

The heart was enlarged with the PMI in the anterior axillary line. No thrills or murmurs were noted but gallop rhythm with a widely split second mitral and second pulmonic sound was present and with $P^2 < A^2$.

The liver was slightly enlarged and soft. The right inguinal hernia had recurred. There was ankle edema but no clubbing of the fingers or cyanosis. Rectal examination was negative.

Laboratory

Laboratory data: The venous pressure was reported as 110 mm. of water with an arm to tongue circulation time of 24 seconds. Total vital capacity was 1.5 liters. The hematocrit was 37% with a sedimentation rate of 9 mm. per hour.

White blood count was 12,600/ cu. mm. with 43 segmented forms, 3 bands, 44 lymphocytes, 10 monocytes, and 3 eosinophils.

Blood sugar was 70 mg% (true glucose), blood urea nitrogen 12.5% mg%, CO_2 content 22.2 mEq/1, serum sodium 130 mEq/1, serum potassium 4.2 mEq/1, serum chlorides 98 mEq/1, phosphorus 3.7 mg%, calcium 10.3 mg%, total proteins 6.1 gm% with albumin of 3.5 gm%, globulin 2.5 gm%.

Serum alkaline phosphatase was 10 King-Armstrong units.

Urinalysis revealed a specific gravity of 1.012 with a trace of albumin. A standard Kahn test was doubtful and a VDRL test was reactive. Cold agglutinins were present in a titer of 1:16. Agglutination tests for Proteus OX-19 and Brucella abortus were negative and the Heterophil antibody test was negative.

Protein bound iodine was 5.6 mg%, and the antistreptolysin titer was 40 Todd units. No LE cells were seen. Repeated examinations of the sputum for acid fast organisms were negative. Total serum bilirubin was 0.5 mg% with a lactic dehydrogenase of 420 units.

X-ray

X-ray of the chest on admission revealed cardiac enlargement especially of the ventricles but also of the atria. There was engorgement of the pulmonary vascular structures and a small collection of fluid in each pleural cavity. Fluoroscopy revealed decreased cardiac pulsation.

An electrocardiogram on admission showed a sinus rhythm with frequent ventricular premature beats. There was a first degree atrial ventricular block, left ventricular hypertrophy and damage, possible atrial hypertrophy, and the possibility of an old posterior myocardial infarction was considered (Fig. 1).

Hospital course

The patient was treated with diuretics, digitalis and a salt-free diet. He became more comfortable with some reduction in the dyspnea. A chest x-ray on April 22 showed slight diminution in heart size with some clearing of the pulmonary congestion. Continued improvement was noted and x-rays on April 30 and May 9 demonstrated further reduction in pulmonary congestion but the left ventricular enlargement persisted.

Repeated electrocardiograms on April 22 and May 11 still showed left ventricular hypertrophy and damage with the possibility of residual anterolateral infarction being considered.

Repeat electrolyte studies showed little change from the initial figures but the WBC dropped to normal limits — 8,400 — by April 17. Serum electrophoresis showed a total protein of 6.1 gm% with albumin 1.8 gm%, $\alpha 1$ 0.5, $\alpha 2$ 0.8, β 1.0 and γglobulin 2.0 gm%.

Repeat circulation time on April 28 was 30 seconds from arm to tongue. On May 7 he was given 5 mg. of Meticorten three times daily and this was reduced

Fig. 1. Electrocardiogram on second admission. First degree atrial ventricular block, left ventricular hypertrophy and damage, possibly atrial hypertrophy. The possibility of an old posterior infarction was considered.

gradually to 5 mg. daily by May 15.

In spite of some diminution in the size of the heart, the pulse rate remained elevated and gallop rhythm was present. A pericardial rub at the left sternal border was thought to be present and from time to time a variable faint murmur was heard. As other measures had failed, antibiotics were started on May 16. He was discharged on May 17, feeling subjectively better but with little clinical improvement.

Third admission June 18, 1959: The major complaint at this time was an increasing dyspnea. Blood pressure was 145/120 with a pulse rate of 120. Cardiac enlargement was still evident and gallop rhythm was present. Liver enlargement was more marked and the edge was soft and tender. The neck veins were markedly distended. There was a leukocytosis of 15,000 per cu. mm. with an essentially normal differential count. Urinalysis was negative.

Additional laboratory findings on this admission included a total cholesterol of 207 mg%; hemoglobin electrophoresis revealed only hemoglobin-A; platelet count was 550,000 per cu.mm. Total blood lipids were 645 mg%. Chest x-rays showed a recurrence of congestive failure in the lungs and pleural effusion on the right side. Infiltrations were present in the lungs consistent with pulmonary infarction (Fig. 2A). It was also suggested that earlier studies had showed some evidence of pericardial effusion. The heart remained enlarged to the left. The electrocardiogram was virtually unchanged. By July 2, he had improved under treatment with digitalis and diuretics, but he complained of an infection of the left great toe which began after he cut his nails with a knife.

Improved

On July 8, he had no complaints except for an occasional uncomfortable feeling in his chest. Pulse rate at this time was 80 and regular. The blood pressure was 108/86. P_2 was still pronounced but there were no murmurs. Edema and distention of the neck veins had cleared. Owing to the good response to treatment on this occasion, he was discharged on July 12, 1959.

Fourth admission August 20, 1959: Again admission was necessitated by severe dyspnea, peripheral edema and upper abdominal tenderness. Blood pressure was 130/100 and all the previously noted signs of cardiac failure had recurred. Two days

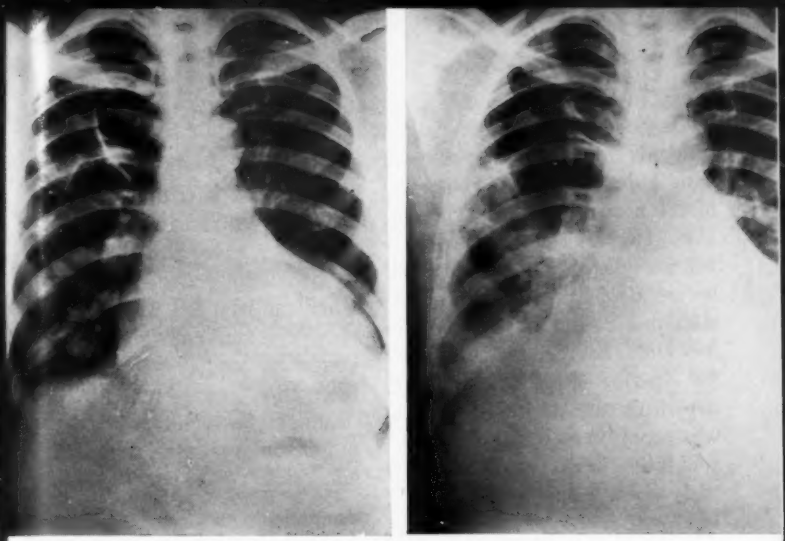


Fig. 2. A—6/27/59: Chest roentgenogram revealed marked cardiac enlargement, primarily left ventricular in type; areas of atelectasis and emphysematous boli in the right upper lobe and probable pulmonary infiltration right lower lobe.

B—8/21/59: Chest roentgenogram revealed two zones of perihilar infiltration have appeared in the right lung with further cardiac enlargement and extension of the changes previously described. There is right pleural effusion as well.

after admission, he complained of severe pains in the chest and an x-ray showed two zones of perihilar infiltration in the right lung (Fig. 2B). A leukocytosis of 13,000 persisted and he developed a spiking temperature up to 102°F. The serum electrolytes were within normal limits. Urinalysis showed 2+ albumin at first, and on a later specimen there were 40 to 50 erythrocytes per high power field with only occasional leukocytes. His condition steadily deteriorated but he was discharged at his own request, on September 2, to attend to some personal business.

Fifth admission September 7, 1959: On this occasion, in addition to dyspnea he had experienced several minor hemoptyses. Blood pressure was 112/94 with a heart rate of 110 per minute and respirations of 30 per minute. There were moist rales in both lungs. The liver was enlarged and tender. There was a trace of ankle edema and the neck veins were distended.

Hypotensive

On September 10, the patient suddenly became hypotensive with a pulse rate of 110. The blood pressure was not obtainable. He was treated with intravenous glucose and water and levophed. Solucortef® was also administered but, in spite of these measures, he remained in shock for a period of ten hours. Lactic dehydrogenase during this period was reported as 3500 units. Serum phosphorus was 4.6 mg% and serum calcium 9.4 mg.%. His systolic blood pressure remained about 100 mm. Hg. but the diastolic pressure was rarely obtainable.

The patient developed hemoptysis on September 21, and on September 25 black necrotic areas were noted on the terminal phalanges of the fingers of the right hand. On September 30, the patient was irrational on occasion and there was definite gangrene of the fingers. Anticoagulant therapy was started with heparin and dicumarol. His condition both mentally and in relation to the cardiac status became gradually worse and by October 14 he had only intermittent lucid periods. Blood urea nitrogen at this time was 22 mg% and there was a neutrophilic leukocytosis of 15,000. Gangrene had developed in his toes as well as his fingers by this time.

On October 24, 650 ml. of bloody fluid was obtained from the left pleural cavity. He continued to have generally severe dyspnea with occasional intervals when the dyspnea was considerably less marked. The signs of congestive cardiac failure and disorientation were present until death on November 4, 1959, 2 months following the last hospital admission.

Congestive failure

DR. BING: This man developed congestive heart failure in a very brief time. His illness lasted only from the middle of April, 1959 to early in September of the same year. During this period he developed progressive shortness of breath, orthopnea, ankle edema, and palpitations.

On physical examination, there appeared progressive signs of congestive heart failure with distention of the jugular veins, gallop rhythm, ankle edema, prolongation of circulation time, diminution of vital capacity, and diminished cardiac pulsation on fluoroscopy. The liver became progressively enlarged. He, undoubtedly, had multiple showers of pulmonary emboli. There were hemoptyses, "engorgement of the

pulmonary vascular structures," and on his third admission, shadows were present in the lung consistent with pulmonary infarction. Pericardial effusion was also thought to be present.

On his fourth admission, following severe pain in the chest, further perihilar consolidation in the right lung was noticed on radiologic examination. On September 21, the patient again developed hemoptysis.

Necrosis

An unusual feature makes its appearance on his fifth admission, when black necrotic areas were noted on the terminal phalanges of the fingers of the right hand. Several days later, gangrene had also developed in his toes. It was at that time that bloody fluid was obtained from the left pleural cavity.

The most significant laboratory finding during the course of illness was an elevation in the lactic acid dehydrogenase. This will be discussed later. His electrocardiogram was first considered to be compatible with an old posterior myocardial infarction and later on, with a residual anterolateral infarction. Evidence of enlargement of both atria and the possibility of a left ventricular lesion (some left axis deviation and T-wave inversion) was entertained. He consistently showed the pattern of left ventricular hypertrophy.

Rapid development

To summarize: We have the pattern of rapidly developing congestive heart failure, pulmonary infarction and peripheral gangrene. What are some of the more frequent causes of rapidly developing heart failure? One must, aside from coronary artery disease due to atherosclerosis, consider heart failure resulting from the group of collagen diseases. Scleroderma, generally known as a cutaneous disease, has been known to affect internal organs and the heart. Weiss and his associates first emphasized the cardiac lesion and employed the term scleroderma heart disease.

Myocardial disturbance results from encroachment and destruction of the muscle fibers. Cor pulmonale may sometimes result from diffuse pulmonary fibrosis. The signs of right-sided heart failure usually predominate. The disease can be one of slow progression, but it may be of rapid onset and course.

Periarteritis nodosa or necrotizing arteritis also affects the heart because the coronary art-

eries are affected in more than 60% of these patients. Thrombosis of a large coronary vessel may result in myocardial infarction, and the clinical picture of coronary occlusion has been observed (Grant, *Clinical Science,* 4:245, 1940). Friedberg in his book mentions one case in which there was massive infarction of the right atrium (Friedberg, *Diseases of the Heart,* 2nd edition, W. B. Saunders Co., 1956, page 440). Congestive heart failure is known to be a common event; hypertension usually precedes it.

Collagen

Disseminated systemic lupus erythematosus usually manifests itself as endocarditis. However, the myocardium also may contain such lesions (L. Gross, *Amer. J. Path.* 16:375, 1940). These consist of fibrinoid necrosis of the supporting structures and of the blood vessels. There may be electrocardiographic changes compatible with acute myocardial infarction and congestive heart failure.

It is therefore conceivable that this patient suffered from one of the collagen diseases. How can we explain the necrosis of the fingers and toes? This may have been due to emboli originating from the left ventricle, although there is no evidence of any specific lesion in the left side of the heart. He did have pulmonary emboli suggesting a lesion or lesions on the right side of the heart. We must, therefore, look for a common denominator for the rapid development of heart failure and the peripheral vascular disease.

Raynaud

Raynaud's phenomenon is known to occur frequently as a precursor of scleroderma. It is known that Raynaud's phenomenon and sclerodactylia are often associated with dysphagia due to esophageal involvement. In our case, Raynaud's phenomenon, if it was such, appears to have been of the true spastic type, characterized by sudden attacks.

The laboratory findings are, in general, non-contributory with the exception of the elevated levels of lactic acid dehydrogenase. The blood level of this enzyme rose within a few months from 420 units to 3,500 units. Elevated serum levels are found in 20% to 50% of patients with malignant tumors. According to West and Zimmerman (West, M., and Zimmerman, H. J. Serum enzymes in hepatic disease, *Medical Clinics North America,*

43:371, 1951), this is observed only in patients with generalized dissemination, including liver metastases, as demonstrated by postmortem examination. In the absence of hepatic involvement, patients with elevated levels are found to have metastases to the myocardium. A small group of patients had elevated enzyme levels, although the tumor had invaded neither liver nor myocardium.

Studies

Recent studies and observations have also suggested that the assay of serum lactic dehydrogenase activity of body fluids such as serum, serous effusion and cerebral spinal fluids may contribute to the diagnosis of malignant neoplasia, primarily in patients with disseminated cancer, lymphoma, or myelogenous leukemia. The significance of the very marked elevation of lactic acid dehydrogenase in our case is obscure unless one assumes a malignancy to be present. It is unlikely that a myocardial infarction would have led to such prolonged elevated levels of lactic acid dehydrogenase.

It is, therefore, my impression that this patient had a collagen disease with rapidly progressing congestive heart failure leading to pulmonary emboli. The nature of this collagen disease is not clear, but it may have been scleroderma or less likely periarteritis nodosa. As mentioned, the elevation of the lactic acid dehydrogenase is a very interesting finding which, unfortunately, does not fit well with this diagnosis.

DR. CLIMIE: This case is an unusual one and teaches an important lesson as the lesion, in some instances, is associated with a diagnosable clinical syndrome. In some cases it may be curable. I think we are able to explain most of the clinical findings from the autopsy findings, although, the cause of the disease is obscure.

There was definite gangrene affecting both the toes and the fingers. The second striking finding was the presence of both fresh and organizing infarcts in both lungs. The lungs were heavy, the right weighing 690 grams and the left 470 grams. Microscopic examination of pulmonary tissue showed organizing infarcts associated with pulmonary arteries occluded by organizing thrombi, some of which showed canalization. More recent hemorrhagic infarcts were also present.

The heart was extremely large, weighing 680 grams. All chambers shared in the enlargement but the right atrium was more

affected than the others. When the left ventricle was opened a mural thrombus was found attached to the lateral wall near the apex, and underlying this was an old myocardial infarction. I think that this thrombus was the source of the emboli which caused the peripheral gangrene, but the possibility of the gangrene occurring as a result of vasospasm following the administration of pressor drugs during the hypotensive episode must be considered as well.

Thrombus

When the right atrium was opened a large ball-like mass was seen which on later examination proved to be a thrombus (Fig. 3). To the left of this mass there was a rough area on the wall of the atrium representing the site of attachment of the pedicle of the thrombus. To the right of the ball-like thrombus, there was an additional mass of thrombotic material attached to the wall of the atrium.

Figure 4 shows the appearance of the right atrium with the thrombus removed, the site of attachment being visible in the fossa ovalis.

Figure 5 demonstrates the laminated appearance of the thrombus on cross section with the

Fig. 3 Large ball-like thrombus in right atri

Fig. 4. Open right atrium following remo of thrombus. Site of attachment in fossa ov

Fig. 5 Laminated character of thrombus with thick rind of condensed fibrin.

rather thick peripheral rind of condensed fibrin. Microscopic examination of the thrombus itself showed almost no evidence of organization and sections through the pedicle show only slight evidence of organization extending out from the endocardium of the right atrium. There was no evidence of damage to the myocardium in the interatrial septum and no evidence of a recent or old inflammatory process.

Most cases of ball-valve thrombi have been reported as occurring in the left atrium. There is a total of between 45 and 50 of these at this time and by far the majority have been associated with mitral stenosis and rheumatic heart disease. The most likely theory of origin is that a thrombus becomes attached to the wall and later becomes pedunculated. With movement of the blood, and some stagnation, more fibrin is deposited on the surface and eventually the pedicle formed may be completely broken so that the mass lies free in the cavity. On the other hand, in some cases such as this, the pedicle remains intact. In general, the association between rheumatic heart disease and right atrial thrombi is not so clear-cut as it is with thrombi in the left atrium. A ball-valve thrombus in the right atrium is a very rare occurrence, and the literature contains reports of only a dozen or so such cases.

TABLE I

OCCLUSIVE THROMBUS OF RIGHT ATRIUM

Syndrome from literature	This case
Dyspnea	+
Cyanosis	?[1]
Venous engorgement	+
Liver engorgement	+
Cardiac enlargement (right atrium)	+
Syncope, coma, convulsions	+
Changing murmur (tricuspid)	+
Pulmonary emboli	+
Varying severity of clinical findings	+
Relief with change of position	?[2]
Atrial fibrillation	—
Old rheumatic disease	—

[1] Cyanosis was not reported but the patient was a Negro.

[2] No attempt was made to demonstrate relief of symptoms with change of position.

Syndrome

There has been much discussion as to whether the term "ball-valve thrombus" can be applied to those masses which remain attached to the atrial wall by a pedicle. Many authors exclude all cases except those in which the mass is totally free within the cavity. From a functional standpoint, I feel this is not justified as it seems that the ball-valve action would be just as evident with a thin pedicle as it would be with the mass lying free. I think there is a definite syndrome associated with occlusive thrombus of the right atrium and Table I illustrates the clinical findings which have been associated with published cases.

The dyspnea is extremely severe and is often unexplained on the basis of physical findings. Cyanosis affects the extremities particularly. The engorgement of the liver and the veins is often associated with systolic pulsation. Cardiac enlargement especially affects the right atrium. Syncope and convulsions occur without adequate explanation. Often a murmur is present which changes from time to time and frequently is in the tricuspid area. Pulmonary emboli are common. One of the most striking features is the varying severity of clinical findings from time to time, and also the relief which occurs with change of position in that when the individual lies down the thrombus is dislodged from the valve and symptoms cease. In the upright position the thrombus impacts and the rapid onset of cardiac failure ensues. Atrial fibrillation and old rheumatic disease are occasionally associated.

With the recent advances in cardiac surgery, cases such as this could be cured by removal of the thrombus.

This syndrome is worth remembering, in that similar cases might be diagnosed and surgical treatment instituted.

Furthermore, in this case, the etiology was not clear. Whether there was a preceding myocarditis which showed no residual evidence of damage in the multiple sections obtained, or whether a minute infarction occurred in the interatrial septum followed by thrombus formation is not known.

FINAL ANATOMICAL DIAGNOSIS: Ball-valve thrombus, right atrium.

DETROIT MEDICAL CENTER

Harper Hospital

Daily medical ward rounds on the staff service are an integral part of house staff training.

Harper Hospital is a voluntary, non-profit, general hospital with 695 beds, 70 bassinets and 20 premature bassinets. Established in 1863, during the Civil War, Harper Hospital first received Union soldiers in 1864. Since that time, it has become an integral institution in the community service of Detroit and the Greater Detroit metropolitan area. At the present time, it shares its two city blocks with the new Rehabilitation Institute of Metropolitan Detroit to which it is intimately connected. The four-story Buhl Building houses the outpatient department and animal laboratory. McLaughlin Hall, the nurses' residence, is located nearby. Across the street, single interns and residents are housed.

The hospital is located about a mile from the downtown shopping and theatre district and the new Civic Center facing the Detroit River. It is within walking distance of the Detroit Art Institute, the Detroit Public Library, the Detroit Historical Museum and the campus of Wayne State University.

Detroit Medical Center

Harper Hospital is now in the center of an urban redevelopment project covering a 238-acre tract. In this area, four major hospitals are combining their facilities with the College of Medicine of Wayne State University to develop one of the finest medical and teaching centers in the world.

Harper's main building, built in 1928, rises eight stories, and with its auxiliary buildings, the Hudson, Harper, and Buhl additions, completes the immediate physical plant. Beginning as a series of frame buildings in 1864 and now planning its centennial celebration in 1964, Harper has undergone a continuing growth to meet the needs of a large metropolitan hospital. The Rehabilitation Institute of Metro-

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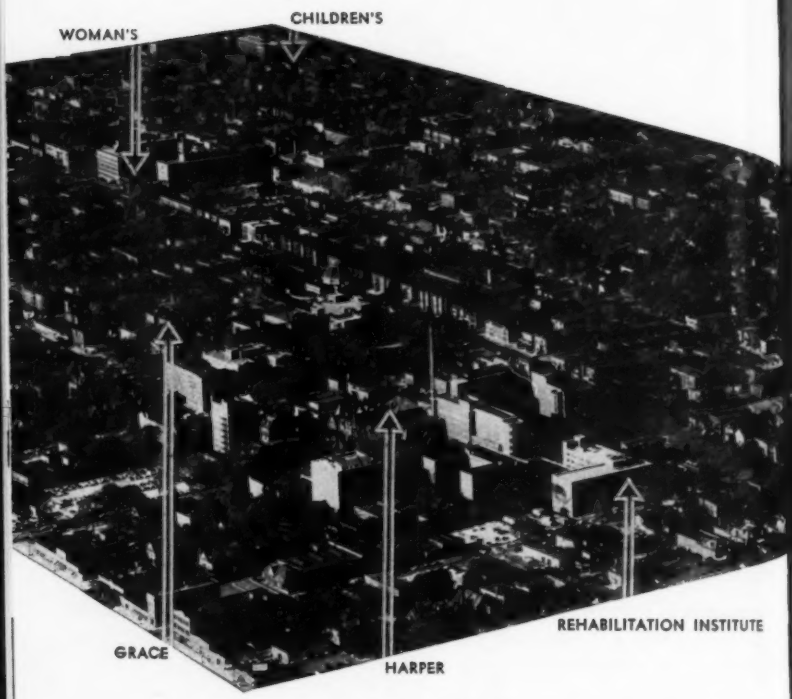

Aerial photo of medical center area with arrows indicating Harper and adjacent hospitals.

politan Detroit contains the latest and most modern facilities for the treatment of the handicapped. All of its facilities are utilized in the intern and resident educational program.

Harper has always been a hospital of specialization, with approximately 95 percent of its staff either certified or eligible for certification by the specialty boards. The hospital is formally affiliated with Wayne State University College of Medicine, many of its staff members holding faculty appointments. In addition to the instruction of its own interns and residents, Harper's educational program includes the instruction of students from the College of

Medicine and its own Schools of Nursing, Medical Technology and Dietetics.

Graduate education

The over-all graduate medical educational program is coordinated by the Committee on Medical Education, the Director of Medical Education, the Intern Educational Committee and the committees responsible for residency training in each department.

Harper Hospital has 28 interns and 87 residents on its staff. Medical students from Wayne State University are assigned in groups during the academic year. There is a total of 486 attending staff physicians.

There is an extensive nursing staff consisting of 150 graduate nurses and about 400 practical nurses and nurses aides. The average patient census is 592 and the yearly OPD census is 43,648.

Internship

A rotating internship only is available, since it is a prerequisite for admission to examination for medical licensure in the State of Michigan.

Living quarters for single interns and residents are located at the Richmond Terrace located adjacent to the hospital. Accommodations for married house officers in limited number are available; assistance in locating living quarters is provided by the Director's office.

Although a personal interview with the Intern Committee is desirable in seeking an appointment, no written examination is required. Prerequisites include graduation from a Class A medical school and a letter of recommendation from the Dean incorporating the opinions of the faculty or, if opinions of the faculty are not included, letters of recommendation from two professors, in addition to a small photograph of the applicant.

The 12 calendar months of the internship are divided into 13 equal periods of four weeks each, during which time the intern is granted certain flexibility in choosing a program best suited to his own interest within the framework of the education program.

A license to practice medicine in Michigan is required of all resident physicians. The Michigan State Board of Registration in Medicine may issue a temporary annual license without examination.

The educational program is specifically integrated with the intern's schedule and attendance

is expected at all teaching functions. Operating room assignments for surgical interns are scheduled to permit attendance at surgical conferences.

Outpatient department

In the outpatient department the interns and residents handle the problems of individual patients under the supervision of the attending staff. Appointments are arranged to permit medical interns to attend conferences. The entire program is designed to encourage the intern to use his consecutive periods in medicine and surgery for follow-up visits of patients he has attended in the hospital. A total of 43,648 patient visits were made to the clinic in 1958 with 14,651 of these in medicine and the remainder in the specialty clinics.

The intern spends one month in the outpatient department with individual responsibility toward patient medical care under the supervision of the resident and assigned attending staff. A weekly teaching conference under the direction of the attending staff is held at which the house staff is present for discussion of problems which have occurred during the preceding week.

The medical residency program includes a rotation in the general medical and specialty clinics. During this period, the resident is required to supervise the general clinic, select interesting and emergency cases for hospital admission, and is responsible for intern teaching.

STIPENDS

The intern stipend is $250 a month plus free meals, uniforms and personal laundry. Married interns receive an additional $50 a month allowance. Residency stipends start at $275 a month and increase $25 a month for each succeeding year. Married residents receive an additional $50 a month. Meals, uniforms and personal laundry are also provided.

Recreation facilities include ping pong, billiards, a card room and a TV lounge at the Richmond Terrace. A double tennis court is located adjacent to the hospital and next door to the nurses home. An interdenominational chapel is to be found on the fourth floor with a full-time hospital chaplain in attendance. Job opportunities for residents' wives are always available. Health insurance coverage for the resident, his wife and children is available through the Michigan Blue Cross plan. The intern receives one week of vacation and the resident two weeks vacation for each year's appointment.

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An emergency room, constructed in 1957, gives Harper the facilities of two emergency operating rooms, a seven-patient examining room and a seven-bed holding ward for emergency cases. Complete x-ray and other laboratory facilities are immediately available in this area. The intern is assigned for a period of four weeks on a day or night basis, with a two-week rotation. Residents in all specialties are available for consultation twenty-four hours a day and the attending staff may be called for further consultation.

The number of emergency visits averages about 9,000 a year. Approximately one-sixth of these cases are admitted to the hospital as emergencies. Trauma, with industrial injuries a main source, is treated in the emergency room except when major surgery is involved.

Residencies

Harper Hospital offers residency programs in eleven specialties, each of which is fully approved for board eligibility by the AMA Council on Medical Education and Hospitals and the respective specialty boards. Residencies are in anesthesiology, general surgery, internal medicine, obstetrics and gynecology, ophthalmology, orthopedic surgery, otorhinolaryngology, pathology, pediatrics, radiology and urology.

Residency appointments are made by January 1 and become effective on July 1. Arrangements are made for residents to attend regional and national

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Committee on Intern Education
John R. McDonald, chairman

Director of Student Teaching
Richard J. Bing, chairman

---

medical meetings and some postgraduate courses each year.

Anesthesiology

In the department of anesthesiology, two yearly appointments are made. Fifteen thousand anesthetics a year are administered by six attending anesthesiologists. Residents administer anesthesia under supervision, employing all agents and techniques. Affiliation with the Children's Hospital of Michigan provides the resident with a three month period of experience in pediatric anesthesiology. Weekly seminars, weekly journal club and resident presentations are included in the didactic program. Basic science instruction and two weekly lectures on anesthesiology are given at Wayne State University College of Medicine.

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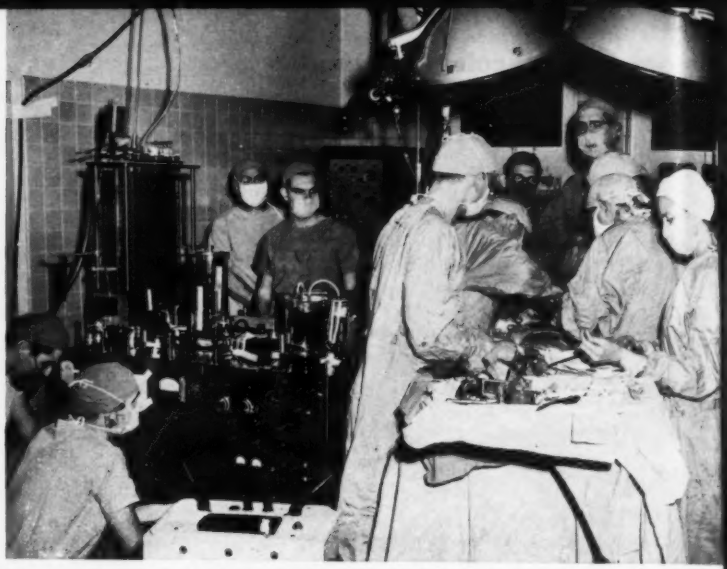


Interns and residents assist at open heart surgery using Mayo-Gibbon heart-lung machi

General surgery

The department of general surgery has 60 attending general surgeons and appoints 10 to 12 first-year residents. Of these, three, or four, receive second year appointments in general surgery, two or three, in orthopedic surgery, one in otorhinolaryngology, and one, or two, in urology. In general, the first year surgical resident performs 100 to 125 operative procedures under close supervision.

During the second or third year, the resident, by special arrangement, may be rotated through the general surgical service of the City of Detroit Receiving Hospital and the Dearborn Veterans Administration Hospital. There are affiliations with Herman Kiefer Hospital for additional thoracic surgical training, Children's Hospital of Michigan for pediatric surgery, Crittenton General Hospital and an industrial hospital.

During the four-year period, each resident will have performed between 500 and 700 operations, all under direct and competent supervision.

Experimental and research projects in the animal laboratory are scheduled weekly. Here the

surgical residents are responsible for instructing interns in surgical technique. Each resident is required to write a clinical paper suitable for publication in the *Harper Hospital Bulletin,* a journal of record, and the senior residents are required to write one or two papers suitable for national publication.

Internal medicine

The department of medicine appoints a minimum of three assistant residents to complete the entire three year program and two or more residents for one year only. A full-time professor and three part-time faculty members from Wayne State University College of Medicine have primary responsibility for the student teaching program and participate actively in the intern-resident program.

Medical resident and intern training is divided between outpatient and inpatient services. The medical outpatient service consists of both general and specialty clinics. The inpatient service consists of two sections, private and student teaching. Scheduled conferences include a specialty course conducted by Harper Hospital staff members and specialists from Wayne State University College of Medicine from 12:00 to 1:00 P.M. on Monday; a medical x-ray conference on Tuesday; weekly grand rounds on Wednesday as well as a medical seminar, journal club, neurology conference, electrocardiographic conference and periodic instruction in selected topics. Two official ward rounds are conducted daily, one in general medicine and the other in the specialties.

Obstetrics, gynecology

The department of obstetrics and gynecology appoints three first-year residents. The first year is devoted to obstetric training as well as problems in obstetrical anesthesia. The second year is devoted to gynecologic operations with pre- and postoperative care through Harper's inpatient and outpatient department of gynecology. A three-month training in pathology and cytopathology is included in this second year. Experience in major and minor gynecologic procedures is given the third year. Ward rounds and weekly seminars are held with the attending staff. Basic science reviews and participation in clinical research projects are required of each resident.

Ophthalmology

The department of ophthalmol-

Main reading room in Harper library.

ogy appoints one or two residents each year. The basic science course is given at Wayne State University College of Medicine in addition to resident seminars and journal club held at the Kresge Eye Institute. During the second and third years, experience at Children's Hospital of Michigan and direct responsibility for all staff surgery as well as experience in other ophthalmologic problems is included in the training program.

Orthopedic surgery

The orthopedic departments of four hospitals including Harper, (and through affiliation with Wayne State University College of Medicine), Children's Hospital of Michigan, City of Detroit Receiving Hospital and the Dearborn Veterans Administration Hospital constitute a joint three-year residency program. Three appointments are made each year. The program includes adult reconstructive orthopedic surgery at Harper; children's reconstructive orthopedic surgery at Children's Hospital of Michigan; bone and joint trauma at Detroit Receiving Hospital and adult reconstructive orthopedic surgery at Veterans Administration Hospital. A basic science course in anatomy, biochemistry, physiology, pathology, neurology and metabolic bone diseases is given concurrently with clinical training.

Otorhinolaryngology

One or two residency appointments are made each year in the department of otorhinolaryngology. One year in general surgery is a prerequisite. During the three year training program all aspects of operative and medical otology, rhinology and laryngology are presented. Affiliations include Wayne University Speech and Hearing Clinic, Herman Kiefer Hospital and Children's Hospital of Michigan.

Pathology

The department of pathology, staffed by a director, four full-time pathologists and a biochemist, offers two first-year residency appointments. Full approval for training in pathological anatomy and clinical pathology is included. Between 10,000 and 11,000 surgical specimens are examined and approximately 325 necropsies done each year. There is an active cytology laboratory and research facilities are available to those interested. Postgraduate courses in pathology, hematology, dermatopathology, bacteriology, parasitic diseases and gynecologic pathology are available.

Pediatrics

Ten to twelve residents are appointed annually in pediatrics. The department has affiliated services at Herman Kiefer Hospital, Detroit Receiving Hospital, Children's Hospital of Michigan and Michigan Epilepsy Center. The residency is divided into 12 to 14 months at Harper Hospital, 6 months at Detroit Receiving Hospital, 3 months at Children's Hospital of Michigan, 1 month at Herman Kiefer Hospital, 1 month in the hematology and chemistry laboratories, and weekly conferences at Michigan Epilepsy Center.

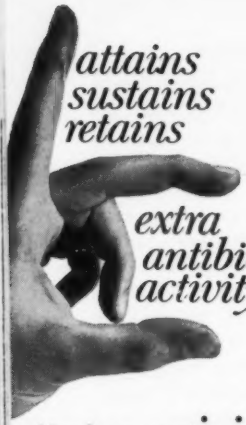
LIBRARY

The Harper Hospital library, staffed by two professional and four assistant librarians, provides the intern and resident staff with an extensive and up-to-date library containing 450 periodicals and 25,000 books and bound journals. Loan facilities are available with Wayne State University, National Library of Medicine and the New York Academy of Medicine. A recreational reading room is attached to the professional library. The library is available to house officers twenty-four hours a day.

Radiology

Three appointments are made each year in the department of radiology which is staffed by 11 radiologists (6 of whom are in full-time attendance), an oral surgeon and a physicist. About 34,000 diagnostic examinations are performed each year and approximately 20,000 deep and supervoltage treatments as well as 100 superficial and 200 radium applications are administered. The division of nuclear medicine conducts 750 diagnostic studies and administers 150 treatments with radioactive isotopes each year.

The residency program is divided into 24 months in diagnostic radiology with 4 months of this period devoted to pediatric ro-



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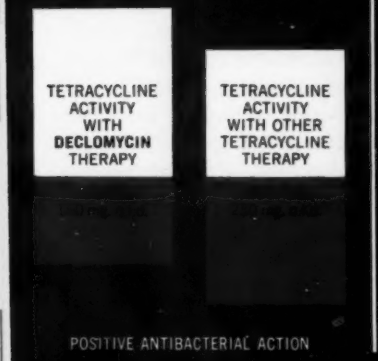
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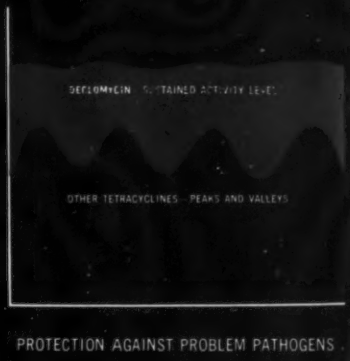

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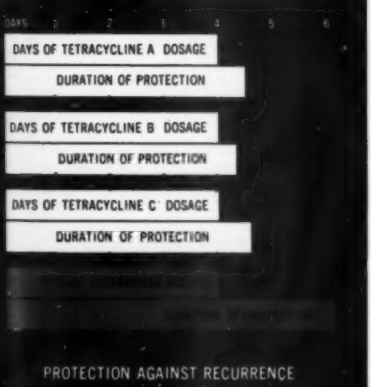
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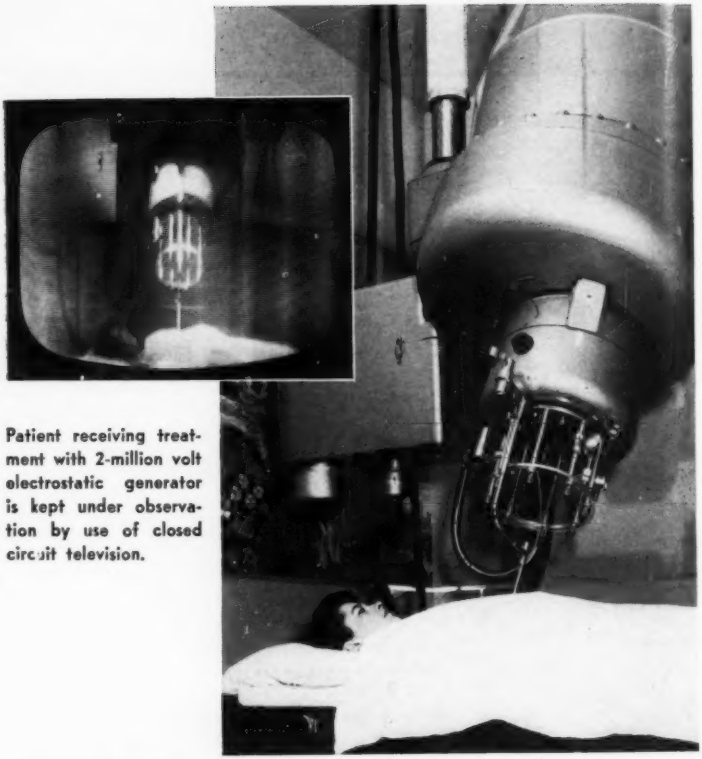
HARPER HOSPITAL CONFERENCE SCHEDULE

MONDAY	
7 - 7:30 A.M.	Eye Rnds.; ENT Conf.
9 -10	Eye Conf. OPD: Med. 4 Center Rnds.; Ped. Nursery Rnds.
10:30-11:30	Med. Specialty Rnds.
9 -12	Wayne - Speech and Audiol.
12 - 1 P.M.	Med. G.I. Conf.
1 - 2	ENT Rnds.
4 - 6	Surg. Animal Lab.
6:30- 8:30	X-ray. Roentgen Diagnosis
7 - 9	Eye, Kresge Institute
TUESDAY	
7 - 7:30 A.M.	Eye Rnds.
7:30- 8:30	OB Rnds.
8 - 9	Path. Slide Conf.; Ped. X-ray Conf.
9 -10	Eye Conf. OPD
10 -11	Med. 4 Center Rnds.
11:30-12:30 P.M.	Urol. Pyelogram Conf.
12 - 1	Med. X-ray Conf.
1 - 2	ENT Rnds.
2 - 3	ENT Animal Lab
3 - 4	OB-GYN Basic Science
4 - 5	ENT Allergy; Surg. Interns' Ward Rnds.
5 - 6	OB Rnds.; Ortho. Jnl. Cl.
5 - 6	X-ray Jnl. Club
5 - 7	Oto. Surg. Anatomy Temp. Bone
6 - 8	Ped. Lecture and Film
6:30- 8:30	X-ray. Therapy and Nuclear Med.
WEDNESDAY	
7 - 7:30 A.M.	Eye Rnds.; ENT Conf.; Gyn. Conf.
8 - 9	Path. Seminar
9 10	Eye Conf. OPD: Med. 4 Center Rnds.
10:30-12	Med. Grand Rnds.
12 - 1	Ped. Jnl. Club (2d and 4th Wednesdays)
1 - 2	ENT Rnds.; Med. Seminar
2:30- 3:30	Gyn. Rnds.

4 - 5	Surg. Case Pres.
6	ENT Rnds., Rec. Hosp.
6:30- 8:30	X-ray. Radiation Physics
7	Oto. Society Meeting
THURSDAY	
7 - 7:30 A.M.	Eye Rnds.; ENT Conf.
7:30	Conf; OB Rnds.
8 - 9	Path. Autopsy Conf.
9 -10	Eye Conf. OPD; Med. Center Rnds.
10 -11	Ped. Epil. Center
10:30-11:30	Med. Specialty Rnds.
11 -12	CPC (1st and 3d Thursdays)
1 - 2 P.M.	ENT Rnds.; Med OPD Conf.
3 - 4	Surg. X-ray Conf. (2d and 4th Thursdays)
3	OB-GYN Basic Science
5 - 6	EKG Course—Lafayette Clinic
FRIDAY	
7 - 7:30 A.M.	Eye Rnds.; ENT Conf.
9 -10	Eye Conf. OPD; Ped. Rnds.
10 -11:30	Med. 4 Center Rnds.
12 - 1 P.M.	Med. Jnl. Club
1 - 2	ENT Rnds.
2:30- 3:30	Med. Neuro. Conf.
3 - 4	OB-Endo. Conf.
4 - 5	Surg. Audio-Dgt.; OB-GYN Weekly Conf.
5 - 6	Ortho.-X-ray Wkly Conf.; OB-GYN Wkly Conf.
6	Monthly Dept. Staff Meeting (2d Friday)
SATURDAY	
8 - 9 A.M.	Eye Rnds.; Surgical Path. Slide Conf.
9 -10	Ortho. Wards Rnds.
9:30-10:30	Surg. Film Club (1st and 3d Saturdays); Grand Rnds. (2d and 4th Saturdays)
11:00-12:00 P.M.	WSU Grand Rnds.
SUNDAY	
9:30-10:30 A.M.	Eye Rnds.



Patient receiving treatment with 2-million volt electrostatic generator is kept under observation by use of closed circuit television.

entgenology at Children's Hospital of Michigan where the resident serves as the chief resident in radiology.

Urology

The department of urology appoints one resident each year with a prerequisite of one year in general surgery or one year in general surgery plus a year in internal medicine, or an equivalent time in research. An affiliated service is maintained at Herman Kiefer Hospital.

Questions regarding the intern program or residencies should be directed to the Director of Medical Education, Harper Hospital, Detroit 1, Michigan.

Malpractice and the General Practitioner

If a general practitioner attempts to treat a patient under circumstances where other GPs would advise a specialist, he may be legally held to the same standards of care as a specialist.

George A. Friedman, M.D., LL.M.

Problems in malpractice which the general practitioner encounters range over the entire medical and surgical field. Yet, as studies have shown, the incidence of malpractice claims against the GP is no greater than against the specialist.[1]

A general practitioner must possess and exercise that reasonable degree of skill, knowledge and care ordinarily possessed and exercised by members of his profession under similar circumstances.

This rule was established late in the nineteenth century. So in a case where plaintiff claimed defendant physician negligently treated him for a rupture of the ligaments whereas the real nature of the injury was a fractured patella, the court in discussing the law of malpractice said:

"The rule in relation to learning and skill does not require the physician to possess that extraordinary learning and skill which belong only to a few men of rare endowments, but such as is possessed by the average member of the medical profession in good standing."[2]

Furthermore, the criterion to

which the general practitioner is held is not that special degree of skill and knowledge possessed by specialists or experts who devote special study and attention to the treatment of a particular organ, disease, or injury.

As the court said in a New York case: "The law does not exact of a physician generally that high degree of knowledge and skill usually possessed by a specialist. The standard by which he is judged is the skill and knowledge of the ordinary practitioner of his locality."[3]

Iowa case

Looking at the question from the point of view of a specialist was a 1950 Iowa case. Defendant physician, an expert on the treatment of varicose veins, cut the artery in plaintiff's leg instead of the vein. Gangrene resulted and amputation proved necessary. In discussing the standard of care required of the specialist the court made two important statements:

"It is to be remembered that defendant physician was an expert or specialist in the treatment of the varicose veins and plaintiff had a right to believe he was more skillful in such matters than the ordinary general practitioner.

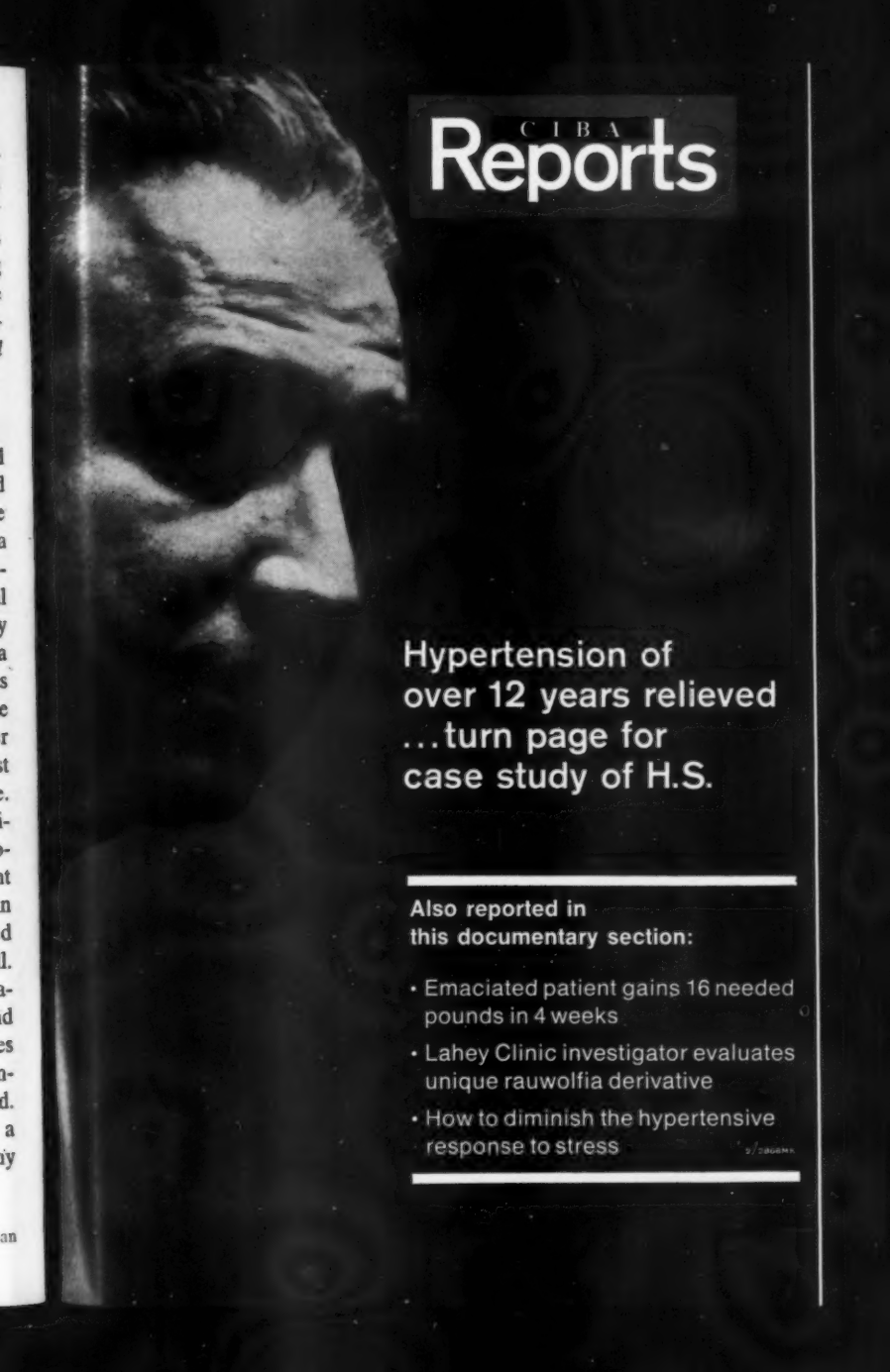
"A specialist is required to exercise that degree of skill and care ordinarily used by similar specialists in like circumstances having regard to the existing state of knowledge in medicine and surgery, *not merely the average skill and care of a general practitioner.*"[4]

Throat ailments

Plaintiff swallowed a small pork bone which became lodged in her esophagus. Within the hour she visited defendant, a general practitioner, for treatment. He made two unsuccessful attempts to remove the bone by using an instrument carrying a piece of surgical cotton on its end. He then advised plaintiff he could do nothing more for her and recommended a specialist who could use an esophagoscope.

The specialist removed surgical cotton from the esophagus together with the bone. Subsequent examination disclosed a tear in the esophageal wall which caused plaintiff to become seriously ill.

Defendant in treating the patient had wrapped cotton around a probe about fourteen inches long and forced it down plaintiff's throat as far as he could. Plaintiff testified: "It caused a sharp pain. Then the bone in my throat slipped . . ."



CIBA

Reports

Hypertension of over 12 years relieved ...turn page for case study of H.S.

Also reported in this documentary section:

- Emaciated patient gains 16 needed pounds in 4 weeks
- Lahey Clinic investigator evaluates unique rauwolfia derivative
- How to diminish the hypertensive response to stress

Defendant removed the probe, wrapped it with cotton again, and tried a second time to remove the bone. Some hemorrhaging occurred.

Several general practitioners testified that the procedure adopted by defendant was not good practice considering the present standards in the profession for the general practitioner and furthermore testified that this procedure would be dangerous.

The jury brought in a verdict for plaintiff in the amount of $7000. Defendant appealed the judgment claiming that the judge instructed the jury that defendant should have exercised the skill of a specialist in treating cases of this kind; that inasmuch as defendant did not claim to be a throat specialist or esophagoscopist, but merely a general practitioner, he should be held to the standards only of a general practitioner.

The appellate court agreed that the standards to be applied in this case were those of other general practitioners. It held however that nothing in the words of the trial judge, namely, "ordinary ability and skill" to be applied with "ordinary care and diligence according to the circumstances of the case," was suggestive of a specialist.[5]

Failure to administer

Plaintiff, a diabetic, injured her thumb at work. It failed to heal properly and she came under the treatment of her employer's physician. The defendant physician removed her nail, but gave no insulin treatment, although plaintiff informed him of her diabetic condition.

Physician continued treating her for five days. During this time he took no blood-sugar test, no urine analysis, and administered no insulin. The infection spread. Plaintiff was removed to a hospital where she received an immediate insulin injection. A portion of the left thumb was amputated, and long incisions made in her left wrist and forearm.

The court held that any skilled physician should have had his suspicions aroused concerning a possible diabetic condition where a comparatively slight injury took such a long time to heal. Plaintiff was awarded $6000.[6]

Defendant was a general practitioner. He diagnosed plaintiff's illness as cerebrospinal syphilis and decided to administer a series of injections of a potent drug preparation known as tryparsamide, an approved treatment for the disease. Plaintiff was given twelve successive injections of this arsenic base drug at intervals

Report

Hypertension of over 12 years relieved with Esidrix®

With Esidrix, Mr. S. was able to conduct his business activities and enjoy his customary fishing trips without discomfort or apprehension.

H. S., a 48-year-old salesman, had been suffering from labile hypertension for over 12 years. Both phenobarbital and rauwolfia had failed to stabilize his blood pressure. Reserpine and chlorothiazide brought some control, but side effects were troublesome. On May 5, 1959, feeling unusually tense, nauseated and dizzy, Mr. H. S. visited his physician.

Work-up disclosed blood pressure of 210/120 mm. Hg, a trace of pretibial edema, heart slightly enlarged to the left, coronal headache, normal urinary function and blood chemistry, and essentially normal EKG. The physician prescribed Esidrix (to be taken with orange juice), and recommended continuation of unrestricted salt diet.

Blood pressure of 210/120 reduced to 140/90 with Esidrix

Date	Therapy	Blood Pressure (mm. Hg)	Observations
5/5/59	Esidrix (taken with orange juice)	210/120	Dizzy, headache.
5/15/59	Esidrix (salt added to diet)	210/120	Muscle cramps.
5/22/59	Esidrix	160/90	Patient greatly improved.
6/5/59	Esidrix	148/90	Improvement maintained. Headaches, dizziness, nausea gone.
6/19/59	Esidrix	140/90	
6/26/59	Esidrix (KCl substituted for orange juice because of gastric distress)	140/90	Patient feels well, but somewhat weak.
7/3/59	Esidrix	140/90	Patient no longer weak; continues to feel well.

Esidrix® for edema and hypertension
(hydrochlorothiazide CIBA)

Photos used with permission of the patient.

2/2860MK

of four or five days. After the third injection plaintiff complained that his "eyes are getting a little blurry." Defendant assured him this condition was only temporary. Plaintiff became virtually blind.

Each ampoule containing the drug had around it a pamphlet in which the directions were clear that there must be immediate cessation of the drug in the event of ocular disturbances.

Judgment was for the plantiff.[7]

Defendant, a general practitioner, treated plaintiff for secondary anemia by injecting liver extract. Plaintiff developed an abscess from which a more serious back condition developed. He was confined to bed for two months with "tubes draining from the back" and had pains for nearly a year. Defendant had previously injected three other patients with extract from the same bottle, all of whom had developed abscesses.

Defendant claimed the fault was the negligent preparation of the extract by the manufacturer. The court held that even were

Report

Combination of Serpasil, Apresoline and Esidrix brings more hypertensive patients under control

In a study of 49 hypertensive patients with blood pressures of 170/100 mm. Hg or more, Dupler et al* report:

10 patients were controlled with Serpasil alone

25 more responded adequately when Esidrix was added

8 more were controlled after the addition of Apresoline to the Serpasil/Esidrix regimen

The investigators conclude that the use of low doses of Serpasil, Apresoline, and Esidrix in combination has "...added to the possibility of bringing more hypertensive patients under adequate control with relatively safe, effective therapy."*

Note: A combination of 0.1 mg. Serpasil, 25 mg. Apresoline hydrochloride, and 15 mg. Esidrix is now available in a single, convenient tablet: **SER-AP-ES®**

*Dupler, D. A., Greenwood, R. J., and Connell, J. T.: J.A.M.A. 174:123 (Sept. 10) 1960.

SERPASIL® (reserpine CIBA)
APRESOLINE® hydrochloride (hydralazine hydrochloride CIBA)
ESIDRIX® (hydrochlorothiazide CIBA)

a/2851MX

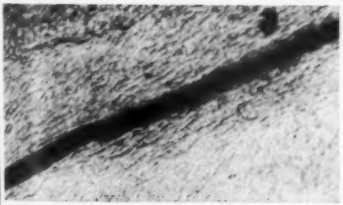
this so defendant was also liable since he had notice that harm to the plaintiff would be likely to follow the injection. He was put on such notice by the abscesses which had developed in his three other patients. There were ample cautionary signals and if, in the face of them, the doctor injected the same substance in the same way into plaintiff his action could reasonably be characterized as negligent.[8]

Plaintiff, a 44-year-old carpenter, fell 12 to 14 feet from a barn and "lit" in a sitting position. Defendant found no injury to the spinal cord or nerves. The next day he took an x-ray from an anteroposterior and not a lateral view. His machine was not equipped with a certain device which would enable him to get a lateral view through the lower back. Only the fourth and fifth lumbar vertebrae showed up on the picture.

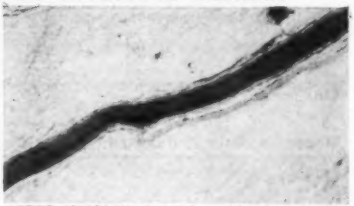
Defendant assured plaintiff he had no broken bones and dismissed him. Plaintiff remained at home for three months, and attempted to walk by pushing a

Report

Photomicrographs show how antihypertensive action of Ismelin® increases arteriole caliber



BEFORE ISMELIN: Photo shows normal arteriole in rat mesentery. (100X)



AFTER ISMELIN: Arteriolar caliber has significantly increased, while an adjacent capillary has filled. (100X)

The pronounced dilating effect Ismelin exerts on blood vessels (as shown above) is manifested clinically by a significant reduction in blood pressure of patients with hypertension. Page and Dustan* report, for example, that Ismelin lowered standing blood pressure to normotensive levels in 17 of 18 patients (94.4%) with hypertensive cardiovascular disease. *Page, I. H., and Dustan, H. P.: J.A.M.A. **170**:1265 (July 11) 1959. 2/2862MK

ISMELIN® sulfate (guanethidine sulfate CIBA)

Report

Report from the Lahey Clinic:
Singoserp® in hypertension

"The most striking result of this [Singoserp] study has been the relief of the undesirable side effects produced by other rauwolfia preparations."*

Singoserp helped lower blood pressure in 40 of 46 hypertensive patients

Therapy	No. of Patients	Results		
		Good	Fair	Poor
1 Singoserp alone – no previous therapy	6	5		1
2 Chlorothiazide alone	3	1		2
3 Singoserp substituted for chlorothiazide in Group 2, above	2	2		
3 Singoserp added to chlorothiazide in Group 2, above	1	1		
4 Whole root or reserpine alone or combined with other antihypertensive agents	37	27	4	6
5 Singoserp substituted for whole root or reserpine in Group 4, above	37	25	7	5

(Adapted from Bartels*)

Singoserp eliminated rauwolfia side effects in 21 of 24 hypertensive patients

Side Effects	Incidence with Prior Rauwolfia Therapy	Incidence with Singoserp
Depression	11	1
Lethargy or fatigue	5	0
Nasal congestion	7	0
Gastrointestinal disturbances	2	2
Conjunctivitis	1	0

(Adapted from Bartels*)

*Bartels, C. C.: New England J. Med. **261**:785 (Oct. 15) 1959.

See the Therapeutic Guide at the end of this documentary section for complete information about indications, dosage, precautions, and side effects of Singoserp.

2/2063HK

chair in front of him. He stayed in bed much of the time and suffered constant pain. At the end of three months he consulted another physician who discovered a compression fracture of the third lumbar vetebrae.

The court held that ordinary care required defendant to use x-ray to aid his diagnosis of the bone injury. Partial x-ray was as useless as no x-ray in this case. The duty on the GP to use x-ray as an aid to diagnosis of bone injuries is no different from the duty of the specialist.[9]

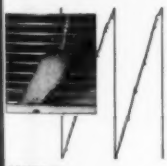
In addition to failure to secure x-rays of the appropriate parts of the skeletal system, many claims of malpractice arise because of failure to secure post-reduction x-rays to show good alignment of fractures.

Other problems

Some of the other causes for malpractice complaints are failure to test for sensitivity to drugs used in diagnostic procedures or treatment; complications from the use of blood or blood plasma; burns and injuries from

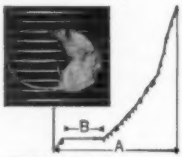
Report

Oversedated rat becomes active again[1] with Ritalin®



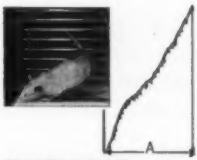
CONTROL

Each slant line of tracings indicates 1000 lever presses by rat trained to work for food. Procedure conducted in Operant Conditioning Apparatus.



SEDATIVE

Activity pattern of rat given sodium pentobarbital 15 mg./kg. Area A indicates time needed, following drug administration, for 1000 lever presses—including inactive period (Area B).



SEDATIVE PLUS RITALIN

Activity pattern of rat given sodium pentobarbital 15 mg./kg. plus Ritalin 10 mg./kg. There is no period of inactivity; sedative effect is considerably lessened.

1. From the CIBA Research Laboratories.

See the Therapeutic Guide at the end of this documentary section for complete information about indications, dosage, precautions, and side effects of Ritalin. 2/2864MK

diathermy and heat lamps and x-rays; improper x-ray dosage or faulty equipment.

When the general practitioner attempts to deal in fields of medicine which require more study and which are a recognized specialty, the line dividing the standards of care between him and the specialist become less pronounced. Some courts in such cases hold the GP to the same standards as the specialist.

When a general practitioner discovers that the patient's ailment is beyond his knowledge or technical skill, it is his duty to so advise his patient and recommend other treatment. If the GP attempts to treat the patient himself under circumstances where other general practitioners would advise a specialist, he is held to the same standard of care as a specialist.

As frequently happens, the courts find it easier to state the general rules than to apply it to each particular case. "The general practitioner's duty must always be measured in relation to the facts in the particular case.

Report

R.C., debilitated postoperative patient, gains 16 pounds of lean tissue on Dianabol®

Photo used with permission of the patient.

Before Dianabol: Patient R.C. was weak and emaciated following surgery to close perforated ulcer. Low-fat diet and multiple-vitamin therapy failed to build him up sufficiently for further necessary surgery (cholecystectomy).

After 4 weeks of oral therapy with Dianabol (5 mg. b.i.d.): Patient had gained 16 pounds of lean weight. Biceps increased 1½". His muscle tone was improved; he felt much stronger. Mr. C.'s physician reports: "He tolerated cholecystectomy very well and one week postop felt better than he has in the past 2 years."

See the Therapeutic Guide at the end of this documentary section for complete information about indications, dosage, precautions, and side effects of Dianabol.

In determining a course of action, he may and should consider such elements as the patient's mental and emotional condition, his known financial situation, and the many other variants which a physician meets in treating human ailments."[10]

Another factor to be taken into consideration is whether an emergency exists and other practitioners more highly qualified are available.

A general practitioner performed an operation for ulcers of the rectum. A broken needle was left in the wound. During the next six months the defendant tried various modes of treatment to cure the resulting pain without success. At no time did he call in a rectal specialist.

Patient finally consulted a proctologist, who discovered and removed the broken needle. The court said that "the localized pain in this case might have suggested to a careful physician the cause of the patient's suffering. A long continuance thereof without relief under the ministrations of the general practitioner might prop-

Report

Doriden® solves sleep problem in this tense, surgical patient

n Doriden, Mrs. Z. slept soundly each night the hospital and awoke without "hangover."

Doriden, 0.5 Gm., was prescribed for Mrs. A. Z. from her first night in the hospital to and including the night before a scheduled thyroidectomy. The patient was continued on Doriden from the day after surgery until her discharge the sixth postoperative day.

Result of Doriden therapy: The patient slept about 7 hours each night, awoke refreshed and without aftereffects. She stated, "That was good because I usually don't sleep very well." Her physician reports that Mrs. Z.'s response to Doriden was "fine."

See the Therapeutic Guide at the end of this documentary section for complete information about indications, dosage, precautions, and side effects of Doriden.

Photo used with permission of the patient.

2/2866MK

erly . . . suggest recourse to a specialist on rectal disorders."

The court did not suggest that the defendant was negligent in breaking the needle, but that the localized pain might have been a warning to a man of skill that the broken needle was at the sensitive spot.[11]

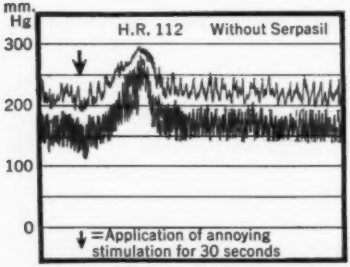
Negligence

A general practitioner treated plaintiff when a foreign substance entered plaintiff's eye. Although he was without the proper instruments to examine the eye, he diagnosed the malady as a common cold and treated patient accordingly. He advised patient at the end of a week, when the condition had worsened, that it might take a month for recovery.

At the time of the original examination and throughout the month the symptoms were those of a "detached retina." The evidence was sufficient to warrant a finding of negligence.[12] An alert practitioner would have been warned by the symptoms, and would not have attempted to treat them. —Continued on page 123

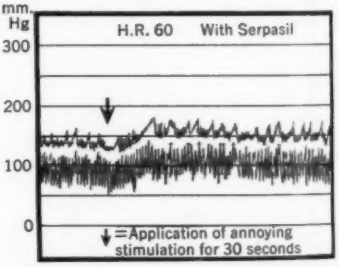
Report

Serpasil® diminishes hypertensive response to stress



Annoying stimulation evokes a rise in blood pressure in the neurogenic hypertensive dog. As shown above, Serpasil diminished this hypertensive response by suppressing sympathetic vasoconstrictor impulses caused by stress.

Dupler et al* note that Serpasil alone produces an adequate blood pressure response in many hypertensive patients.



They point out: "It is particularly useful for tense and anxious patients and those who are subject to simple tachycardia."*

*Dupler, D. A., Greenwood, R. J., and Connell, J. T.: J.A.M.A. **174**:123 (Sept. 10) 1960.

See the Therapeutic Guide at the end of this documentary section for complete information about indications, dosage, precautions, and side effects of Serpasil.

2/2607MS

More difficulty is experienced by the courts in deciding cases involving treatment of fractures. At what point—if at all—should the case be referred to an orthopedic man? When the fracture fails to mend after treatment or immediately, without attempting treatment? *This question can only be answered by each doctor on the facts of each case.*

Two somewhat similar leg fracture cases in different courts were decided differently. In both cases there was a non-union of bones after the usual maximum period for the healing of a leg fracture. Both physicians thought ultimate success was assured. The delay in proper treatment in both cases caused poor final results.

In one case the court held that physician was not negligent, but made an error in judgment which was not actionable.[13] In the other case physician was liable for malpractice in not recommending a surgical operation by a specialist or experienced bone surgeon.[14]

Where there are no symptoms to warn physician that his diagnosis is erroneous or that the ailment is not responding to treatment, he cannot of course be liable for failure to recommend a specialist.

Physician treated plaintiff for conjunctivitis instead of glau-

"We've heard from surgery, cardiology, radiology, pathology and the lab report . . . and now for the summation, diagnosis and final word, I'll turn the meeting over to the Blue Shield-Blue Cross representative."

coma and he became totally blind. Testimony brought out that diagnosis and treatment of this rare disease could be made only by specialists. Its prominent symptoms however are so nearly identical with those of conjunctivitis that the diagnosis made by defendant was one reasonably to be expected from a general practitioner.[15]

Plaintiff, a rancher in Lodi, California, suffered complicated leg fractures which defendant, a general practitioner, undertook to treat. As a result of the treatment plaintiff suffered partial, if not total, and permanent disability. The closest orthopedic man was fourteen miles away. The fracture was rare and complicated, and no emergency existed.

The court held that the general practitioner should have referred patient to a specialist. "The general practitioner, and not the patient is in a better position to know when the services of a specialist are called for."

The court went on to say that where the general practitioner undertakes a specialized service and if in his locality there are those who specialize or whose practice is limited to that particular branch of the healing professions, then it is his duty to possess that degree of learning and skill ordinarily possessed by those who specialize in such practice in that locality.[16]

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1. Sadusk, "Analysis of Professional Factors in Medical Malpractice Claims," 161 J. Am. Med. Assoc. 442 (1956).
2. Pike v. Honsinger, 155 N.Y. 201, 49 N.E. 760, 762 (1898).
3. Greenstein v. Fornell, 143 Misc. 880, 257 N.Y.S. 673, 678 (1932).
4. McGillpin v. Bessmer, 43 N.W. 2d 121, 128 (Iowa, 1950).
5. Dixon v. Norberg, 157 P2d 131 (Colo., 1945).
6. Greenstein v. Fornell, supra, footnote 4.
7. Reed v. Church, 175 Va. 284, S.E. 2d 285 (1940).
8. Henderson v. National Drug Co. et al. 343 Pa. 601, 23A, 2d 743 (1942).
9. Wilson v. Corbin, 41 N.W. 2d 702 (Iowa, 1950).
10. Simone v. Sabo, 37 Cal. 2d 253, 231 P2d 19 (Calif., 1951).
11. Benson v. Dean, 232 N.Y. 52, 133 N.E. 125 (1921).
12. Smith v. Mallinckrodt Chemical Works, 212 Mo. App. 158, 251. S.W. 155 (1923).
13. Bickford v. Lawson, 81 P2d 216 (Calif., 1938).
14. Tvedt v. Haugen, 294 N.W. 183 (N.D. 1940).
15. Wohlert v. Seibert, 23 Pa. Super. Ct. 213 (1903).
16. Sinz v. Owens, 196 P2d 52 (Calif., 1948).

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Here is a dramatically new and different surgical adhesive tape. We urge you to try it. Quite possibly it is the tape you will wish to use in your practice and recommend to your patients from now on.

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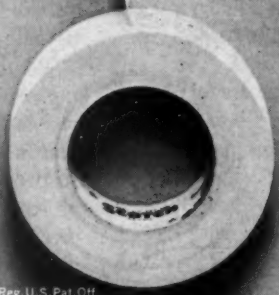

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1. Golden, T.: Am. J. Surg. 100: 760, 1960.

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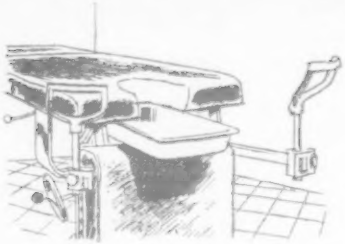

Patien Rec

Recording Gyn diagnoses is essentially the same as other diagnoses with these added factors: The chart should contain not only the complete history of pregnancies, with the outcome of each; the complete menstrual history with accurate notation re any abnormal bleeding; but if possible, as full a history of sex response as can be gotten without psychic trauma to the patient.

Where there is a history of abnormal bleeding per vagina, a visible lesion or other definitive reason why malignancy should be suspected, it is the responsibility of the gynecologist to follow through and complete his diagnosis with appropriate biopsies. If for any reason this is contraindicated, the chart should state why you made such a decision.

The following findings should be *recorded:*

1. *L*
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Records in Ob–Gyn

Mary D. Westover

1. *Labia or Vulva:* Obvious pathology or lesions?

2. *Pelvic Support:* Cystocele? Urethrocele? Rectocele? Enterocele? Descensus?

3. *External Genital Glands:* Obvious pathology or lesions:

4. *Vagina:* Mucosa without gross pathology? Stimulation in keeping with age? Blood in vaginal vault? Old or fresh? Excess mucus? Smear taken? Culture taken? For what tests?

5. *Cervix:* Normal size and consistency? Well epithelized? Nabothian cysts? Os open? Old lacerations or scars? Freely movable? Lugol stain? Pap smear?

6. *Corpus:* Position? Relative size? Consistency? Smooth and regular? If irregularities or masses (palpate) what type and where? Freely movable?

7. *Adnexa:* Masses or induration palpable? Relative size of ovaries?

Your report on a diagnostic dilation and curettage, with or without biopsy or conization should include:

1. Type of anesthesia? General? Paracervical block?

2. Pelvic examination, as above.

3. Biopsy? Punch? Quadrant? Specimens separately marked? Hemostasis by?

4. Conization? Hot or cold? Cervical aspects marked on specimen? Hemostasis by? Complete?

5. Uterine cavity sounded to? Cervical canal dilated to? Be sure to state that both of these were without event, if true.

6. Sponge or ovum forceps? Sharp or dull curette? Amount and gross appearance of curettings? Polyps or polypoid tissue? Did you note any irregularities in the endometrial cavity? Where and what type? Was all tissue sent to the path lab? Separately

marked: i.e., endocervical or endometrial? By whom?

7. Blood loss? Hemostasis verified at end of procedure? Vaginal pack?

8. Some statement that it is felt certain that the uterine wall was not perforated at any point.

The permissive statement, obtained before any gynecological surgery, should set forth clearly that it has been explained to both husband and wife that because of the disease process it might prove necessary to remove viscera which would inhibit or preclude child-bearing, and should state that this is fully understood before the surgery was agreed to. *Both husband and wife should give such permission.*

Where extensive surgery is contemplated, particularly where radiation therapy has taken place or is contemplated following surgery, and there is a definite possibility of ureteral or intestinal complications, this fact should be explained to the patient and her husband in terms they can understand — and so recorded. (With faultless technique, tissue changes may appear months later, and the patient may well be convinced that the surgeon, not the disease process, is the culprit, unless this has been carefully explained before surgery is attempted.)

Whenever the pelvis is opened, *record* the condition of all internal genitalia in detail, even that a given viscus is surgically absent. Are the bladder and both ureters within normal limits? Was an upper abdominal exploration done? If so, *record* detailed findings. What about the appendix? Were there marked adhesions that might later interfere with function? If extensive lesions are lysed, *record* that no viscera were compromised by reason of the lysis, if this is true.

When necessary to interfere with pregnancy (for whatever medical reason), if the patient is from a Catholic background, in addition to the usual medical-legal forms, *record* that the fetus was baptized. This is important to Catholic parents.

Prenatal care

1. The prenatal history should include:

- Marital history.
- Para? Gravida? Term? Premature? Abortion? Stillborn? Twins? Now living? Age at death of any child?
- Menstrual history: Average frequency of periods. Average length of period. Last normal period. Last menstrual flow. Abnormal vaginal discharge?
- Complications of previous

after 5 years of research and 41,000 patient days of clinical testing

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1. Macy, I. G.; Kelly, H. J., and Sloan, R. E.; with the Consultation of the Committee on Maternal and Child Feeding of the Food and Nutrition Board, National Research Council: The Composition of Milks, Publication 254, National Academy of Sciences and National Research Council, Revised 1953. 2. Brown, G. W.; Tuholski, J. M.; Sauer, L. W.; Minsk, L. D., and Rosenstern, I.: Evaluation of Prepared Milks in Infant Nutrition; Use of the Latin Square Technique, J. Pediat. 56:391 (Mar.) 1960.

Mead Johnson

Symbol of service in medicine

pregnancies? Bleeding? Toxemia? Hypertension? Size of babies and length of labor in each case? Doctors records available, if these would help?

- History of previous pertinent illnesses.
- History of all previous surgery, with name of surgeon and operative reports, if possible.
- Drug sensitivities, especially to drugs commonly used at time of delivery.

2. Besides the standard complete physical and the pelvic examination, as given previously, the record of the physical examination should include: Pelvic measurements. Weight chart. Accurate reason for abdominal scars if present, to rule out the possibility of previous cesarean section.

3. Lab tests done during pregnancy should include: Periodic urinalyses, Pap smear, hematology and blood chemistry on mother (including serology), Rh factor of both parents and blood type of both parents.

At the time of admission for delivery the necessary permissive forms should be signed by the patient and/or husband *before* any sedation is given. Circumcision permit? Permit for cesarean section, if this becomes imperative? Tubal ligation?

Virtually all hospitals have regular delivery room forms, and for uncomplicated deliveries these are all that will be necessary. Any complication, including perineal, cervical or vaginal tears beyond a routine episiotomy, should be *fully written up* in the progress note on the hospital chart, and it is a good practice to use a carbon paper and keep a copy for your own office chart. (Some hospitals routinely provide verifax copies of pertinent portions of charts.)

The physician, not the nurse or hospital personnel, is responsible for birth information given parents (sex of child, etc. and *he should give it personally if possible).*

Information as to sex or condition of child, condition of mother, or other details given to unauthorized persons is the responsibility of the attending phy-

"UPSET STOMACH" ON DIGITALIS 52-year old male had rheumatic heart disease, cardiomegaly Grade II, auricular fibrillation, mitral stenosis, mitral insufficiency, and was in class III-C. For 17 months he had been in failure. Three grains of digitalis daily were required for effective maintenance therapy. When the patient began to complain of frequent "upset stomach", he was placed on digitoxin, with an alternating 0.1 and 0.2 daily maintenance dose. Nausea became very severe after two months, and digitoxin was decreased to 0.1 mg. daily. Congestive failure increased and rehospitalization was necessary. Patient was given GITALIGIN, 0.5 mg. q.i.d. for two days, then 1.5 mg. daily for six weeks, followed by 1.0 mg. per day with 1.5 mg. every third day. Failure was effectively controlled without toxicity.[1]

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"...patients who became toxic very readily with other agents could later be satisfactorily digitalized with gitalin (GITALIGIN)."[2] Wider margin of safety—frequently effective in patients refractory to other digitalis glycosides • broader clinical utility—therapeutic dose only ⅓ the toxic dose • faster rate of elimination than digitoxin or digitalis leaf. ☐ Supplied: 0.5 mg. scored tablets—bottles of 30 and 100.

1. Dimitroff, S. P. et al.: Ann. Int. Med. 39:1189, 1953. 2. Pastor, B. H.: GP 22:85, 1960.

†Amorphous gitalin, White

White WHITE LABORATORIES, INC. • Kenilworth, New Jersey

sician, regardless of who gives it. The *patient* is the *only* one who can release such information.

Since unequivocal identification of the infant is not only your responsibility, but is a prime factor in the well-being of the mother, whatever the practice in the hospital to eliminate error in this respect, you should see that *both* parents are completely satisfied as to the baby's identity, *and so record.*

The following form for the operative report on cesarean sections is suggested:

Preoperative Diagnosis: Intrauterine (term?) Pregnancy, in labor (?), reason for procedure. (e.g. history of previous cesarean section, cephalopelvic disproportion, etc.)

Postoperative Diagnosis: Same or same amplified.

Title of Operation: Primary (or repeat) Cesarean Section, (give type).

Body: After the induction of (?) anesthesia, and with a catheter in place, the surgical field was prepared and draped in the routine manner for cesarean section. A (low midline?) incision was made (incise previous scar?). Dissection was carried (through linea alba?) retracting the recti laterally. Hemostasis? Ties? Bovie?

The peritoneum was carefully incised between clamps. Develop bladder flap, and retract bladder out of the field. A transverse (?) incision was made in the lower portion of the uterus and amniotic fluid aspirated. Incision manually (?) extended revealing the child in (?) position and child was extracted manually (?). Suction child? Condition? Cry spontaneously? Strip cord and clamp; divide and ligate cord, and give child to (?). Remove, examine and report intactness of placenta. Check uterine cavity for further deciduus? Establish vaginal drainage? Close uterus how? (Be sure to describe defects in uterine wall which might affect future pregnancies.) Examine and describe adnexa bilaterally. Verify hemostasis, record sponge count correct, and close abdominal wall in layers, using (?) sutures of (?) material in peritoneum (did you include posterior sheath in this layer?) Retention sutures? Anterior sheath closed how? Subcutaneous closed how? Skin closed how? Pressure dressing? Estimated blood loss? (Replacement?) Parenteral fluids? Complications? Immediate post-op condition? *Treatment recommendations for future pregnancies.*

Next Month: SURGERY RECORDS

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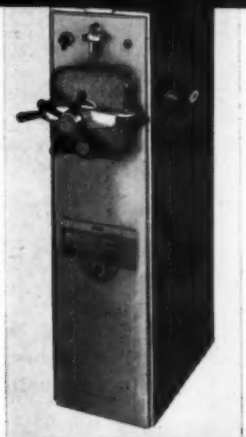

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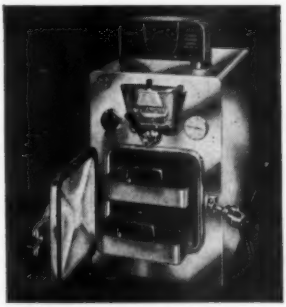

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The Modern Nurse and Her Station

Is nursing to be done by clinical clerks and interns because the girls in the white uniforms are too busy with clerical duties to have time for it?

Paul A. Hein, Jr., M.D.

A subtle change has taken place in the architecture of our hospitals.

I am not referring to the lovely pastel operating rooms with built-in circuit breakers and electric tables, nor to the bigger-than-ever gift shops.

I mean the phenomenon known as The Nursing Station.

In the older hospitals where I served, The Nursing Station was nothing you would pay particular attention to. In fact, you might even pass it by now and then or —miss it altogether. It was a nook opposite the elevators. Charts were kept there. Cabinets on one wall contained medicines, and perhaps there was a small room adjacent where the nurses could relax and have a cup of coffee when things were slow.

Command HQ

By contrast, a nursing station in one of our modern hospitals resembles nothing so much as the Command Headquarters of the Strategic Air Command. It is a large, glass-enclosed cubicle, brilliantly but indirectly lighted. It may or may not protrude into the hall; either way it affords the best visibility with the least locomotion. On either side are corridors. Through one of these doctors may gain access to the charts, which are arrayed in a rack separating this corridor from The Station.

In the other corridor one finds

an icebox, hotplate, and cabinets for drugs. Here too is a doorway through which Authorized Persons can gain access to The Station itself. Thus the nurses, like the Vestal Virgins, are effectively protected from disturbing outside influences.

Face-to-face

Anyone determined to communicate with the nurse face-to-face can do so by addressing himself to a hole cut in the glass at about the level of his xiphoid, through which the nurse will reply. Below this, where the glass meets the counter-top, there is another larger hole through which small packages can be thrust. The counter at which the nurse sits extends off to either side. On it rests the imposing console of the intercom by means of which the nurse can speak to ("Station to 2150, Station to 2150, Do you read me? . . .") or to be spoken to ("Station, this is 2150—Mayday, Mayday") by the patient.

Also on the counter are two telephones, white, with pushbuttons, and the ingoing and outcoming terminals of the vacuum tube system.

Other prominent features of The Station are the counter under the chart rack, where the doctors' orders are carefully transcribed onto tiny cards (which are immediately smudged and discarded) and the filing cabinet containing forms.

So much for the anatomy of the place, now let's see it in action. The apogee of modern nursing.

Mrs. Brown, a new patient, having somehow survived the rigors of the administration desk, arrives at The Station accompanied by a Grey lady, or a Pink lady, or some such. The admission diagnosis is pharyngitis, chronic, and she really does have this nasty cold which she just hasn't been able to shake off, probably aggravated by the paint fumes in her apartment, which is being redecorated. Since she has Blue Cross, this seems the logical time to get to the bottom of those sniffles.

Instructions

The nurse greets Mrs. Brown throught the hole in the glass, assigns her to 1832, writes "20" on the Graphic Sheet under "Respirations," and delegates an aide to make a sortee to 1832 to admit Mrs. Brown, which means taking her pulse and temperature. She also gives her an inspiring educational booklet ("This is YOUR hospital") and instructions on using the intercom

tomorrow she'll need..

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Winter activity often calls soft and unused muscles into play. To relieve the frequently painful consequences, a logical choice is PARAFON. Combining a superior muscle relaxant with a preferred musculoskeletal analgesic, PARAFON promptly alleviates pain and stiffness, restores mobility, and accelerates recovery. Just 2 tablets provide up to 6 hours of relief. PARAFON is effective in musculoskeletal disorders, such as sprains, strains, myositis, whiplash injuries, low back pain, and fibrositis. Side effects are rare, almost never require cessation of therapy.

Dosage: Two tablets t.i.d. or q.i.d.

Supplied: Scored, pink tablets, bottles of 50. Each tablet contains PARAFLEX® Chlorzoxazone† 125 mg., and TYLENOL® Acetaminophen 300 mg.

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("Speak slowly. Identify yourself. DO NOT MUMBLE!").

Station alert

Meanwhile, back at The Station, the Communications Nurse is displaying her virtuosity with the telephone. While waiting for the intern to answer his page on one phone, she uses the other one to call the diet kitchen. On being connected with the intern, she gives him his orders and then uses that phone to inquire of the pharmacy if they have vitamin C lozenges, while calling the admission desk on the other phone to tell them that the patient for 1832 has arrived and wishes to transfer to 1841. "Permission granted," says the admission desk, as the nurse dials the lab for a blood count. Her right hand free, she answers the intercom, which is Mrs. Brown stating, distinctly and slowly, without any mumbling at all, that she has fallen off the bed in 1841, and may, or may not, be hurt. Mrs. Brown having said "over and out," the nurse records the blood count coming into her left ear from the lab and then dials the Nursing Office on the left-hand phone, informing them of an accident (Red Alert), and the intern on the right-hand phone, requesting him to make a prompt appearance to sign the Accident Form, which has already been placed in the chart by the Forms Nurse.

Of course, things aren't always this slow. Sometimes she has to get help.

Stuff

But if the important work of the Communications Nurse is glamorous, no less important is the work of the Medication Nurse. This devoted young woman, wearing powerful spectacles, hunches over the chart, transcribing the doctors orders onto tiny bits of cardboard, which are then handed over to a student nurse who smears them slightly and hides them.

This insures that if Mrs. Brown gets any medicine at all, it will be more or less the right stuff.

This gives you a rough idea of what modern nursing is all about. It is, of course, a gross oversimplification, and should be accepted as such.

Obviously it is a job calling for training and dedication.

For instance, it is rumored that within the next few years, nursing stations will become equipped with radar. This will require still further communications training. In addition, a certain amount of medical training is required, so that when talking with

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the intern, or clerk, the nurse can give him a fairly clear idea of what needs to be done for the patient.

Challenge

Finally, she must be a skilled administrator, able to deal with all sorts of people: supervisors, aides, students, volunteers, orderlies, telephone operators and repairmen, hospital administrators and technicians.

She must be polite and attentive to doctors, even though it means taking time from her work.

Finally, in the presence of a real emergency, with interruption of telephone service, she must be willing to leave her Station and go to the bedside; even, if necessary, to physically contact the patient. Greater love than this no man hath!

This, then, is the sublime challenge of nursing! Given the modern hospital and the modern nurse, is it any wonder that the doctor of today can do so much for his patient?

"I don't smoke!"

Population, the Mind, ESP, Rage, Violence, Conscience . . .

Resident Physician's editor presents here the last of a three-part commentary on the recent Dartmouth College Convocation on Great Issues.

The first speaker at the Evening Assembly, Mahomedali C. Chagla, Indian Ambassador to the U.S., spoke on the problems faced by India which are associated with its rapidly expanding population. His was a factual and moving discourse. India has four hundred million people. The average per capita income ($2100 a year in the U.S.) reaches only $60 a year in India. Poverty, squalor, ignorance, and low standards of living are the rule.

"People will turn to totalitarian methods if they are driven to poverty and if they can find no relief by adhering to free and democratic institutions." India, he said, has maintained about the same birth rate, but, due primarily to sanitary and certain preventive medical measures, the death rate has dropped sharply. As he put it, "we have been suffering from the civilizing effects of science and medical research. Civilization has shown us how to reduce our death rate but so far has failed to point the way to a controlled population. I think this is one of the most important issues of conscience in modern medicine.

"Medicine must advance on both fronts. If

it considers life is sacred and everything must be done to prolong it, it must also prevent human beings from being born into an existence of poverty, destitution and frustration. The sanctity of life demands that the dignity of the individual must be upheld. *What dignity will millions of children have who are being born today?"* (Italics mine, Ed.)

Fertility research

"This country [U.S.A.] has fought a ceaseless war against diseases in different parts of the world. There are national institutes of health and other organizations which are carrying on unceasing research in cancer, malaria, typhoid and other fell diseases which the human flesh is heir to. But the Government and official institutions fight shy of doing research on the problem of human fertility. Why? To my mind, increasing population is a more terrible sickness from which a country can suffer than the diseases with which medical science is presently concerned. Cancer or malaria can only kill the body. When you have unwanted children, when you have children you cannot feed or clothe or educate, you maim the soul — you leave a scar which destroys equanimity of mind and twists and distorts the human personality. I have heard it being said that this country should remain neutral on the question of . . . family planning in a foreign country. I have no desire to interfere in the domestic policy of this country . . . But this is something that concerns the whole world . . . I am sure that if it is once realized that the increase in population is a grave menace facing the world, then this country will also realize this menace must be fought on a global basis.

Birth control

". . . I would like to say a word about the ethical or moral aspects of the problem. To my mind morality consists of giving the least pain to fellow human beings and contributing to the largest extent to their well-being . . . Applying this text, I think you are causing more misery and suffering to untold millions by denying a knowledge of birth control technique than by doing everything possible to bring home to the people of this country the vital urgency of the problem of population explosion which is facing the world . . . I would rather prevent life than bring into existence children who do not and cannot live as human

You can–and should–adjust dosage with Orinase just as you do with insulin

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A slight upward adjustment of Orinase dosage is often the only step needed to establish or regain optimum control of diabetes. The increase serves to make available the amount of Orinase-released native insulin *required* by the patient. The change may be made freely, to 3 grams or more a day, because Orinase has virtually no "ceiling" imposed on dosage by toxicity or untoward effects.

To maintain smooth control, to avoid needless "secondary failures," give sufficient Orinase to meet the varying needs of different patients or the varying needs of an individual patient.

1. CASE DATA COURTESY HENRY DOLGER, M.D.

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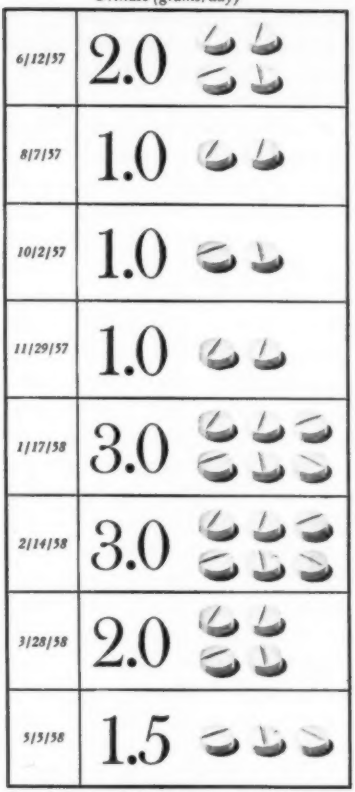

Actual doses used to maintain optimum control in patient J.S., male, age 54[1]

For those diabetics who won't stick to their diets, add appetite-suppressing ***Didrex***† *(benzphetamine, 50 mg. per tablet).*

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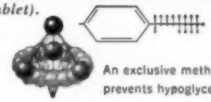

An exclusive methyl "governor" prevents hypoglycemia

beings and who are a scandal both to Providence and to man."

The Ambassador then went on to outline what India had done to meet this problem. But how pitifully short she was of reaching the desired goal. He concluded his talk by saying, "We have to fight poverty in India on two fronts—on the economic front by industrialization and on the population front by ways and means for reducing the birth rate. America has given us generous aid to carry on the fight on the first front. We want your great scientific, technical and medical knowledge and experience to wage an equally effective war on the second front. It's only when the conscience of the people has been aroused that the war will be successfully waged." The applause which greeted the end of the Ambassador's discourse was not equalled before or later in the Convocation! It was overwhelming in its volume and time.

Quantity vs quality

The second speaker of the evening session was Aldous Huxley, who has been in the forefront of those concerned with the developing population explosion, and who obviously was the drawing-card of the Convocation. His theme was built around the question of *"Quantity Versus Quality"* a topic which should be of great interest to all concerned with the future of medical care and of this country. (See editorial, "On the Quantity and Quality of Life," RESIDENT PHYSICIAN, May 1960.)

Mr. Huxley developed his theme by pointing out that "it took 1600 years for the 259 millions inhabiting the planet in 1 A.D. to double their numbers. It will take just 40 years for the 2.9 billions of 1960 to become 6 billions." The reason: normal or higher birth rates, with sharp drops in the death rates in those categories of disease which formerly slew millions in childhood, and from adulthood through middle age.

We can ask what the effects of this explosion may be for us. Well it will mean that our standard of living will not rise rapidly. Also, the quality of living may be affected. Children will be brought up in "supercities," completely out of touch with nature. Public beaches, national parks, resort areas, wild-life sanctuaries, etc., will be grossly overcrowded.

In underdeveloped countries, the "explosion" will, because of a lack of money, skill and trained personnel, produce intense nationalism and a trend towards

totalitarianism. (This is already becoming very evident in Ghana, Guinea, and the former Belgian Congo.) Frustrations will be great, as the attempt to counterbalance the excess of population by hard work will not be effective. Poverty and bad governments will move hand in hand towards the standards of communism. In the backward countries, military machines will be developed, and the Cold War intensified. Russia and Red China will be contesting the United States all over the world!

Two courses

The question is whether anything can be done about it. Huxley asked the question, "What are the humane and rational substitutes for Nature's methods of dealing with over-population—namely, famine, pestilence and (in human societies) war?"

He believes that "two courses are open to us. Both must be pursued simultaneously." We must increase the production of industrial goods and food all over the world. This is feasible. Secondly, we must do something to control birth rates so they come into balance with death rates. This will be difficult, Huxley said, if not almost impossible. There are major obstacles, ". . . chemical, medical, sociological, psychological, educational, and in some quarters theological." Currently no birth control method is cheap and easy to use. The "Pill" which can be easily and cheaply used by hundreds of millions of people has no. been invented. Even if we had it tomorrow, Huxley pointed out, the population problem would be very grave. An immediate drop of twenty percent in births would mean that a vast number of children would still be born. He concluded by saying, "While *a national population policy internationally agreed upon, would not bring an immediate solution to our problems, it must nevertheless be adopted. If it is not, our grandchildren and great grandchildren will be in for the worst time of troubles ever faced by the human race. Increasing quantity will result in deteriorating quality of living, and most of the world will sink into abysmal squalor and chronic warfare.*" (Italics mine. Ed.)

This is the dismal future as predicted by Mr. Huxley. Naturally, his remarks, though somewhat lengthy and repetitive, received close attention and were vigorously applauded. However, to your Editor's ear, the applause was not as forceful nor as sus-

tained as that for Ambassador Chagla.

Influence the mind

On the final morning of the Convocation, the topic for discussion by a panel was "The Issues Involved in Influencing the Mind." The chairman of this panel, Professor Ralph W. Gerard, Mental Health Research Institute, University of Michigan, opened the discussion by saying brainwise, man really differed little from animals. What makes the difference is the mind. He went on to say that science is not ethically neutral. It has something to say about the ends themselves. He postulated that in a sense, with the development of "supercities," we must develop a race of supermen who will be able to get along with themselves under the conditions which will exist in these massive aggregations of population.

Love of fellow

Dr. Wilder Penfield, director of the Montreal Neurological Institute, then spoke up inquiring whether "the roar of the waterfall of doom" is not becoming distinctly audible. He pointed out that excesses of all types (including population) should be our national concern. He then launched into a discussion of the mind. Consciousness, he stated, means activity of the mind. As far as brainwashing is concerned, its technique is no more scientific than that of torture or solitary confinement. Furthermore, hypnosis and subliminal activity produce no lasting effects on the mind. To date Dr. Penfield said, science has provided no method of controlling the mind. One cannot force the mind to do your bidding, or the person who owns it. He believes that the innate kindliness of man holds great hope for the future. Art of and religion in medicine play a real role. The Art with its ethics has a peculiar meaning and The Hippocratic Oath itself is an indenture. He concluded by saying that study of the brain had not explained the mind, and that in his opinion *"men must love their fellow men or be destroyed. This only can save this muddled generation from rushing on to destruction."* (Italics mine. Ed.)

Dr. Sandor Rado, president, New York School of Psychiatry, next spoke on the fascinating topic of "Rage, Violence and Conscience." In his words, "Today, a fit of rage may terminate civilization. Rage is the enemy of civilized man . . . contemporary society must . . . tame rage, check

... violence . . . and . . . develop machinery for making the moral code effective . . . we call the components of this organic machinery the mechanisms of conscience . . . Medically speaking, conscience may be defined as an organization of self-restraining and facilitating mechanisms concerned with the regulation of human conduct. These mechanisms stem from the organism's basic orientation towards repeating pleasant experiences and avoiding painful ones."

The speaker pointed out that the "fear of inescapable punishment" was in part a bolster of conscience, especially in the developmental period. However, retroflexed rage dominating conscience is dangerous. He said, "guilty fear and the purely emotional repair work of expiation have little value in adult life. The rational response to one's wrongdoing is to apologize, pay damages, and be satisfied with learning one's lesson for good... Rage is an open threat to the survival of the species. Retroflexed rage, by means of which 'traditionally' organized conscience operates, is an insidious threat to the health and life of the individual. In order to prevail against these threats, maximal research effort should be made towards reducing the strength of rage to manageable levels, and to improving the traditional organization of the conscience."

Control

Discussion was opened by Sir Charles Snow who observed that conscience has an inhibitory meaning and unless there is great drive, conscience may render one impotent in various ways.

Mr. Huxley brought out the point that we could learn much from the ancient Greeks on how to treat rage and frustration by physical and muscular therapy. He told of witnessing frustrated, poverty-stricken, Brazilian Negroes dancing all night in Bahia to work off their tensions. He felt that psycho-physical methods of controlling rage should be more carefully evaluated.

Then, Sir Charles, with a wicked sparkle in his eye, opined that rage was an occupational disability of people who have drive, i.e., world figures, big businessmen, prima donnas, etc.; the type which are always "hitting the ceiling." Dr. McDermott then observed that surgeons used to be notable for their rages in the operating room, but that now this doesn't occur. (It could be wondered, how many operating rooms he has been in lately.)

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1. Davies, O. L., Raventos, J., and Walpole, A. L.: Brit. J. Pharmacol., 1:255,1946.

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ESP

Dr. Brock Chisholm then thought out loud about how much imagination has been crippled by too rigid internalized conscience control, i.e., that one way of thinking is "good," the other "bad." He pointed out that one must not confuse thinking with behavior and that the imagination must be limbered up or it cannot be used fully.

Mr. Warren Weaver then raised the question of extra-sensory perception, stating that, in respect to it, he cannot reject the evidence, but he cannot accept the conclusions. What then is the effect of mind on mind? He pointed out that the statistical evidence for the 25 card extra-sensory perception experiment is thousands of times more impressive than is the evidence that smoking causes lung cancer. Professor Gerard ruled extra-sensory perception summarily out of the discussion remarking, that people have extra senses. Dr. Penfield closed the discussion by stating that as yet science has not explained these matters by which men live and that, in living, Religion had given leadership, while Science had given none.

The Honorary Degree Assembly, held to the tunes of bagpipes, took place the last afternoon. Degrees were awarded to Sir Charles Snow, Sir George Pickering, Dr. Brock Chisholm, Aldous Huxley, Ambassador Chagla, and Dr. Wilder Penfield.

Sir Charles Snow was the speaker of the occasion and, in his address, he reviewed the problems discussed at the Convocation sessions, notably those dealing with atomic fallout, overpopulation, and the genetic quality of the human race. Sir Charles was positive that "the new dangers are very real and will require for their solution all of our intelligence and guts." He pointed out that one of the major concepts developed in the Convocation was that "medical conscience is no longer exercised solely within the private domain of the doctor-patient relationship but is being extended into the broader field of public action through what is coming to be known as statistical morality." He stated that "It is clear, however, that some eugenic measures being proposed would be extremely difficult to put into effect in a free society."

PERRIN H. LONG, M.D.
Resident Physician

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QUIET, PLEASE!

YOUR WIFE'S TALKING

There are those who claim that a doctor's wife requires the same emotional equipment as the wife of any other male in this modern society. But from letters we've received, there are many aspects of a doctor's marriage which take special handling from the wife's point of view.

Joan Morse

Some experienced wives of doctors were briefing "new groups," recent brides of young interns, at a recent informal gathering. Although the conversation was not intended as a press conference, you may find their opinions challenging . . . and helpful.

"What is most important for a doctor's wife to remember?" asked one of the recently married young ladies.

"Patience and patients . . . , " quipped a wife whose husband is an anesthetist at a large hospital, " . . . seriously, you must already be learning how to wait for your husband. Try not to resent his hours away from you. Understand his fatigue when he finally comes home. Your attitude will be all right if you are able to remember that patients come first—for both of you."

"Will marriage to a doctor affect our family life?" was the next query.

The wife of a busy diabetic specialist, mother of two small boys, picked this one up. "The doctor's wife must

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1. Hirsh, B. D.: Medicolegal Digest, 1:21, June, 1960.

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realize her husband's time is not *his* own and, therefore, not *her* own. If she adjusts to this aspect of marriage to a doctor, it will be no different than marriage to any other professional man. Plans and programs should be arranged as in any other family. Yet we always make the mental reservation that Daddy may not be there. I have found it better not to promise the children his presence than to give them the impression he will be free, and have to disappoint them at the last minute. Children find uncertainty about plans difficult to handle, but it is always pleasant when Daddy's presence is a surprise!"

Quiet, please!

"Is there a rule which applies to all medical wives?" the bride wondered.

"To keep quiet," the senior gals agreed as one voice. "Don't talk about your husband's patients. Don't even mention that a certain individual *is* his patient. Learn from the start to respect professional confidence in which you will often be involved."

"As a doctor's wife, will I be expected to behave according to any particular pattern?" was the next question.

The discussion which followed made this point:

It depends upon the doctor's community and his type of practice.

A wife whose husband's office was downtown felt comfortable wearing slacks in the suburbs where they lived, since this is an accepted custom among the young matrons in her neighborhood. But the wife of a local general practitioner recalled the druggist's wife warning her never to appear in public without lipstick!

A pediatrician's spouse mentioned their decision not to attend a certain local New Year's Eve party at which everyone would be expected to drink.

In general, wives of doctors should resist any impulse they may have to "wave a red flag;" they should conform generally to the standards of their community.

Respect

"Medical wives usually are respected," continued the wife of a young surgeon. "With that respect goes responsibility. As a doctor's wife, you are continually involved in public relations. You represent your husband and his profession to the community."

"You will often be asked for advice about medical problems," said another. It is definitely *not* your job to diagnose and treat the

patient. You can, however, help others to find out how they may obtain care for their particular problem. When people are upset over an incident involving services of a physician, nurse, or hospital, you may be able to interpret the professional viewpoint. All doctor's wives should keep informed concerning medical resources in their own areas."

"Membership in the Women's Auxiliary of your District Medical Society will help to keep you informed," suggested the wife of a dermatologist, herself an Auxiliary secretary. "I was able to explain the Salk vaccine crisis in our state to many who asked me about it because the Auxiliary had kept me up-to-date. Besides, we are the only group organized to take action when bills involving medical care appear before the state legislature."

"You've opened up a big subject," said an intern's spouse. "I have been wondering how much I will be expected to participate in community affairs. It sounds overwhelming when I hear what the wives of our staff members accomplish. They volunteer in all kinds of hospital work, serving patients directly as well as fund raising. They are board members of social agencies, leaders in health and welfare drives, not to mention the usual activities of mothers whose children involve them in PTA, Scouts, and Little League. Some wives are secretaries for their husbands. Others hold paid jobs everywhere from the public school guidance department to nursing here at the hospital. Most intern wives expect to work. But what happens when our husbands start in practice? How do we find time for everything?"

"My husband and I don't agree on this subject," said the wife of an internist. I think it is important in building a practice for a doctor's wife to be as active as possible in community affairs. He believes that if a man is a good doctor, patients will come to him for that reason alone."

"Perhaps you're both right—My feeling is you should follow

ABOUT THE AUTHOR

A graduate of Wellesley College and Simmons School of Social Work, the author had been a medical social worker at Massachusetts General Hospital. At present, Mrs. Morse is a housewife and mother of four children. Her hobbies include playing the clarinet, bicycling, free-lance writing, "and the usual PTA, Cub Scouts and Brownies."

your own interests," stated the wife of the diabetic specialist. "Those with time and means should always try to use them to serve others."

Paying proposition

"When a doctor's family joins in activities such as Little League," pointed out the pediatrician's wife, "they indicate the physician's approval of such programs. We must train ourselves to think before joining, and then support the causes with which we really want to be identified."

"What about a paid job for the wife whose husband has an active practice?" asked a neophyte doctor's wife.

"I know one doctor who did not want his wife to work for money because people might think he was unable to support his family," said the lady who had married a dermatologist. "The wife involved had five children, all in school. She went ahead anyway with a morning job at the nearby hospital, mostly as a change from the monotony of housework. Her husband finally permitted her to keep the job, but asked the hospital not to pay her a salary!"

"That sounds like a case of clashing temperaments," said the surgeon's spouse. "I have been able to continue medical social work on a part-time basis, when I can arrange care for the children. Right now I'm helping out in my husband's office. Being your husband's secretary has its pros and cons. It's embarrassing if a patient wants to complain to the secretary about the doctor's bad habits!"

"In our case, I feel the doctor's wife is an essential part of her husband's practice," explained the wife of the general practitioner. "From the beginning I set a pattern of being available to help my husband whenever and however he needed me. It would have been no different if he happened to be running a grocery store. The basic pattern still continues, even though now my husband has a busy practice with an office staff and telephone service at home. One keeps putting off one's own interests for the sake of the practice and the children. Sometimes I wonder how long it is desirable to continue this way."

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Nonmedical

"Medical wives have a responsibility to cultivate interests in the nonmedical fields for which their husbands have so little time," countered the anesthetist's wife. "It is surprising how many members of our local League of Women Voters, for instance, are wives of busy doctors. The women can also maintain a real interest in art and music, potential sources of relaxation for their husbands in whatever leisure they may have available."

"Maybe I help my husband to be a better doctor when I can get him off biking with me now and then," said the pediatrician's wife. "Doctors often forget that exercise is necessary to their own well-being unless we give them a little push."

By this time, the brides were so filled with good advice, each would have qualified as the wife of the chief of staff. Yet they listened patiently while one of the seniors gave her a final word. "If your husband gains a reputation in his community for being unusually thoughtful and understanding with his patients, remember he may have to let off steam somewhere. It may well be at you!"

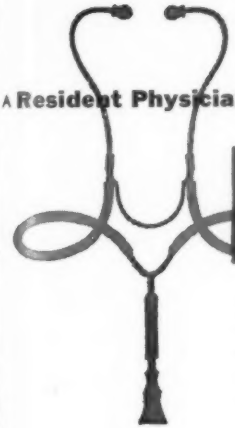
Osler Said This . . .

ABOUT THE ROLE OF THE PRACTITIONER

Often the best part of your work will have nothing to do with potions or powders, but with the exercise of an influence of the strong upon the weak, of the righteous upon the wicked, of the wise upon the foolish. To you, as the trusted family counsellor, the father will come with his anxieties, the mother with her hidden grief, the daughter with her trials, and the son with his follies. Fully one-third of the work you do will be entered in other books than yours. Courage and cheerfulness will not only carry you over the rough places of life, but will enable you to bring comfort and help to the weak-hearted and will console you in the sad hours when, like Uncle Toby, you have to whistle that you may not weep.

DR. WILLIAM OSLER, 1849-1919

A **Resident Physician** MONTHLY FEATURE



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These questions were prepared especially for RESIDENT PHYSICIAN *by the Professional Examination Service, a division of the American Public Health Association. Answers will be found on page 168.*

1. Administration of ACTH to a normal subject will increase his output of all the following hormones *except:*

A) 11 , 1 -Dehydroxyandrostenedione.

B) Aldosterone.

C) Corticosterone.

D) Hydrocortisone.

E) Cortisone.

2. The term apraxia may be defined as:

A) Inability to recognize familiar sounds despite normal hearing.

B) Inability to perform purposeful movements at will despite understanding and an intact motor apparatus.

C) Difficulty of speech due to paralysis of the muscles employed.

D) Ability to whisper without the ability to speak aloud.

E) Inability to recognize familiar objects despite normal vision.

3. A physiological intestinal defect present in sprue is:

A) Absence of peristaltic waves.

B) Over-response to cholinergic agents.

C) Abnormally low basal intraluminal pressure.

D) Failure of internal sphincters to open.

E) Hyperperistalsis.

4. Chlorpromazine reduces

nausea and vomiting in uremia by affecting the:

A) Vestibular nuclei.
B) Labyrinthine canals.
C) Frontal lobes.
D) Vomiting center.
E) Chemoreceptive trigger zone.

5. All of the following statements about herpes simplex are true *except* that:

A) Histological examination of lesions reveals intranuclear inclusion bodies.
B) The tissues preferentially attacked are derivatives of embryonic ectoderm.
C) The virus is seldom recovered from tissue.
D) Visible manifestations are characterized by vesicle formation.
E) Clinical manifestations of the herpes simplex virus other than the dermal one are relatively common.

6. Which one of the following conditions is *not* a feature of Wilson's disease?

A) Amino-aciduria.
B) Hemosiderosis.
C) Cirrhosis.
D) Glycosuria.
E) Cupriuria.

7. In a patient with Reiter's syndrome, it is wise to test for:

A) Hypoadrenalism.
B) Gonorrhea.
C) Traces of heavy metal.

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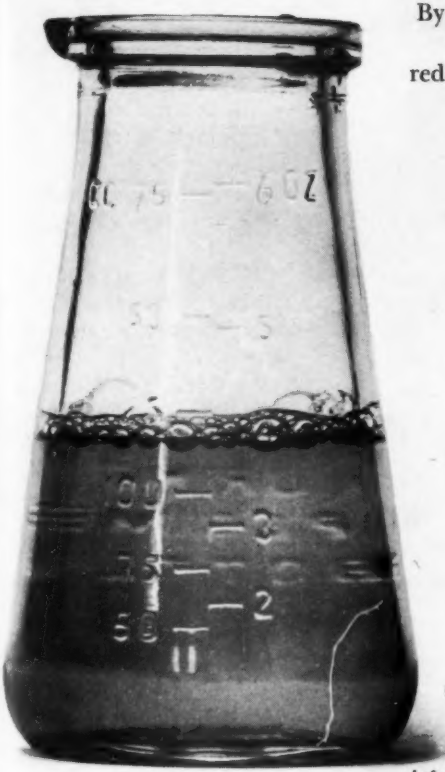

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D) Parasagittal meningioma.
E) Occult hemolysis of circulating erythrocytes.

8. Anticoagulant effect and antithrombotic effect are:
A) Produced by different anticoagulants.
B) The same.
C) Always correlated.
D) Never correlated.
E) Not necessarily correlated.

9. A patient has received 500 cc. of whole blood intravenously during the first hour of a 2-hour gastrectomy under intravenous thiopental and nitrous oxide - ether - oxygen anesthesia. The strongest evidence of a reaction to this transfusion would most likely be:
A) A sudden fall in blood pressure.
B) An abrupt increase in temperature.
C) Postoperative hematuria.
D) Postoperative shaking chills.
E) Intermittent chills during surgery.

P. S. you are now reading Resident Physician pioneer journal and leader in articles of value to house staffers

10. Acute hemorrhagic necrosis of the pancreas occurs most frequently in individuals who are:
A) Obese and young.
B) Obese and middle-aged.
C) Cachectic and middle-aged.
D) Cachectic and senile.
E) Suffering from nutritional edema.

11. Patients receiving bacitracin should be watched for evidence of:
A) Marrow depression.
B) Hepatocellular damage.
C) Renal injury.
D) Exfoliative dermatitis.
E) Intestinal tract bleeding.

12. Of the following the most effective treatment for lymphosarcoma is:

They

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1. Cornely, D. A., and Ritter, J. A.: N-acetyl-p-aminophenol (Tylenol Elixir) as a Pediatric Antipyretic-Analgesic. J.A.M.A. 169:1219 (Apr. 7) 1956
2. Mintz, A. A.: Management of the Febrile Child. J. Ky. Acad. Gen. Pract. 5:26 (Jan.) 1956.

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A) Roentgen ray therapy.
B) A-methopterin.
C) Tri-ethylene melamine.
D) Urethane.
E) Myleran.

13 Band keratopathy is usually associated with all of the following conditions *except:*
A) Uremia.
B) Renal tubular acidosis.
C) Sarcoidosis.
D) Hyperparathyroidism.
E) Vitamin D intoxication.

14. Fever in the course of congestive heart failure is usually due to:
A) Lobar pneumonia.
B) Myocardial infarction.
C) Bronchopneumonia.
D) A nonspecific infection.
E) Unknown causes.

15. As a patient with hepatic disease recovers, fistula bile might show a:
A) Decrease in volume and increase in protein.
B) Decrease in volume and bile salts.
C) Increase in electrolytes, albumin, and glucose.
D) Increase in volume and hemoglobin.
E) Decrease in chlorides and increase in bile salts.

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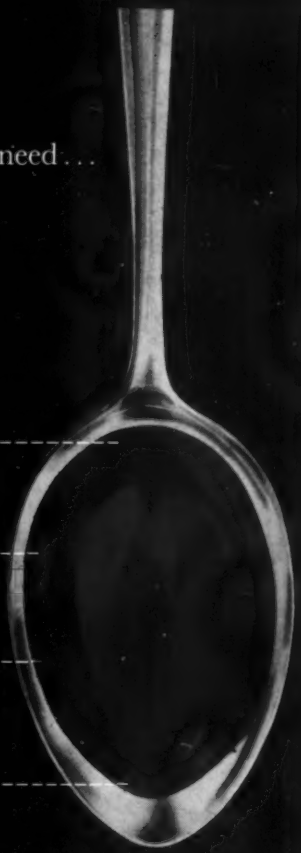
(exempt narcotic), when additional cough
suppressant action is needed.



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What's the Doctor's Name?

He was the founder of an old-age pension plan in the 30's that bore his name and which he devised while serving as an assistant health director in Long Beach, California. At its height, it was backed by 5,000 clubs of some 5,000,000 members who gathered 25,000,000 signatures. Eighty per cent of California's enrolled voters were said to have been included.

The plan called for a $200-a-month pension for everyone who retired at 60, the money to be spent the same month it was distributed and to be financed by a two percent tax on business transactions. Later it was changed to ask support from a three percent tax on all employed persons.

The group claimed 2,000 clubs in 1957, and its founder gained White House appointments with Presidents Truman and Eisenhower, but it had waned as a

national influence in 1936 when the doctor came out for the third-party candidacy of William Lemke for the presidency in alliance with the Rev. Charles E. Coughlin and Gerald L. K. Smith.

The son of a farmer, he was born in a log cabin in Fairbury, Illinois, and in the course of his education was noted for his wide memory and retentive memory. When he and his brother invested in Los Angeles land during a real estate boom and lost their savings when they raised hay on it, he returned to the midwest, working his way through Omaha Medical College. At 30 he was the oldest graduate in his class. In 1903 he went to the Black Hills of South Dakota as assistant to a physician. He served in the Army Medical Corps in World War I.

He accepted payments from Social Security for the first time at 83, calling it an unfair program that gave the least money to those who needed it most.

His wife, a nurse, died in 1951, and he died, at 93, on September 1, 1960. His son directs the plan's headquarters in Washington. Can you name this doctor?

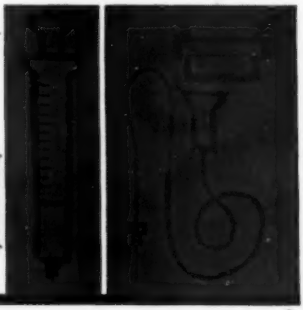
(Answer on page 168)

Intravenous, vials,
100 mg. (with 250 mg. Vit. C),
250 mg. (with 625 mg. Vit. C),
500 mg. (with 1250 mg. Vit. C).

IV

Intramuscular, vials,
100 mg. (with 250 mg. Vit. C),
250 mg. (with 275 mg. Vit. C).
(each with procaine HCl 40 mg., magnesium chloride 46.84 mg.)

IM



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VIEWBOX DIAGNOSIS

(from page 23)

ANNULAR PANCREAS

Note the napkin-ring constriction of a one-inch segment of the mid third of the descending duodenum. This was constant throughout the fluoroscopic and film examination. The mucosa is preserved. The pathognomonic feature of this diagnosis is the smallness of the mucosal folds in the constricted area, resulting from the congenital constriction which never permitted these folds to attain maturity.

MEDIQUIZ ANSWERS

(from page 159)

1 (B), 2 (B), 3 (C), 4 (E), 5 (C), 6 (B), 7 (B), 8 (E), 9 (C), 10 (B), 11 (C), 12 (A), 13 (B), 14 (E), 15 (E).

WHAT'S THE DOCTOR'S NAME?

(Answer from page 166)

FRANCIS TOWNSEND

RESIDENT RELAXER

(puzzle on page 29)

V	I	R	U	S	■	H	O	G	■	P	A	P	E	R
A	T	O	L	E	■	Q	R	A	■	E	L	E	M	I
L	I	V	E	R	■	G	A	S	T	R	I	T	I	S
E	S	E	■	P	E	A	L	■	R	T	■	A	L	E
■	■	■	L	I	M	N	■	M	E	A	S	L	E	S
D	O	S	A	G	E	■	T	U	M	I	D	■	■	■
A	L	A	M	O	■	C	O	L	O	N	■	S	O	N
F	I	N	E	■	B	O	N	E	R	■	S	E	M	I
T	O	E	■	P	A	R	I	S	■	O	P	T	I	C
■	■	■	I	L	I	A	C	■	O	P	I	A	T	E
I	N	S	T	A	L	L	■	S	U	E	T	■	■	■
N	E	Y	■	N	E	■	C	A	R	R	■	E	L	M
G	E	N	O	T	Y	P	E	S	■	A	P	N	E	A
O	L	O	N	A	■	E	L	I	■	T	O	T	A	L
T	E	D	E	R	■	W	E	N	■	E	X	E	R	S